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ABSTRACT

This document is comprised of the one issue in volume 5 of "Bridges," a publication produced by the California Head Start-State Collaboration Office to detail the activities of the educational partnership and to provide relevant information to programs participating in the partnership. The Fall 2000 issue focuses on children with challenging behaviors and shares some of the latest thinking about how best to meet the social and emotional needs of children. This issue includes articles on: (1) fostering infant/family mental health; (2) providing mental health treatment for infants, toddlers, and families; (3) training and technical assistance related to young children with mental health and behavioral disorders; (4) resources for reflective thinking regarding challenging behavior; (5) problem-solving steps as a tool for reflective thinking; (6) relationship-based mental health consultation model; (7) responsive teaching; (8) early intervention for children with behavior problems; and (9) descriptions of Head Start partnerships with higher education and child care programs. Also included are Web site resources. (KB)

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BRIDGES

California Head Start-State Collaboration Office

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Michael Zito, Editor

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BRIDGES
CALIFORNIA HEAD START-STATE COLLABORATION OFFICE

Message from the California Head Start–State Collaboration Office

by Michael Silver, Director, and Michael Zito, Coordinator

If you ever have been particularly frustrated and challenged by the behavior of a child at work or home, this issue of *Bridges* is meant for you. According to a recent survey, 78 percent of Head Start staff report that their number-one priority for technical assistance is working with children who present challenging behaviors.[1]

In a related vein, a disturbing study recently published in the *Journal of the American Medical Association* reported a two- to three-fold increase between 1991 and 1995 in the use of stimulants, such as Ritalin, and antidepressants, such as Prozac, in children two to four years old. In a *Sacramento Bee* article on the study, Doctor Steven Hyman, director of the National Institute of Mental Health, said he was "more than shocked" by the findings. The *Bee* article further reported that while the use of these drugs is increasing, accurate diagnosis of behavioral problems in preschoolers "is iffy at best." Sacramento pediatrician Richard Gould added that diagnosing behavior problems in toddlers is very difficult, "because a three-year-old with attention deficit is acting like a three-year-old by definition."

This issue of *Bridges* is intended to share with you some of the latest thinking about how best to meet the social and emotional needs of the children in your care. We have solicited articles from some frontline practitioners working in the field as well as from those developing policy at the state level. You will find articles on how current brain research is being put to practice in pilot programs around the state, hands-on practical assistance you can use now with the children in your care, and direction on where to call if you need to obtain professional mental health assistance for a child. You will also find updated information on how to refer parents to California's Healthy Families and Medi-Cal health programs as well as other information and web resources that we hope you will find useful.

This issue of Bridges *is intended to share with you some of the latest thinking about how best to meet the social and emotional needs of the children in your care.*

We note the retirement of Maria Balakshin, former director of the California Department of Education's Child Development Division (CDD), and the elevation of Michael Jett as the new director. We wish both of them well in their new endeavors. We also welcome Ray Hernandez as the recently elected president of the California Head Start Association (CHSA) and Edward Condon as CHSA's new executive director. CHSA and CDD are primary partners in many of CHSSCO's activities.

[1] Development Associates, California's Quality Improvement Center—the technical assistance provider for Head Start

News from the California Head Start Association

The election of board officers for the California Head Start Association (CHSA), held in March 2000, had the largest voter response in CHSA history. Congratulations to all of you! This underscores our belief in your commitment to quality child education and development services in California.

We, the newly elected officers—Raymond Hernandez, president; Patricia Dash, vice president; Tracy Tomasky, secretary; and Alicia Ramirez, treasurer—have been working with other members of the CHSA board of directors to set the goals for the enhancement and expansion of services to eligible families in the Head Start and Early Head Start programs and to the communities we serve. During the general membership meeting in San Diego, May 10 to 12, 2000, the board members finalized the CHSA strategic plan for next year, outlining the association's concrete goals and objectives and setting completion timelines. The plan formalizes our resolution to address the issues and challenges faced by CHSA and those we serve.

Welfare reform has changed how we provide services to the families in Head Start and Early Head Start programs. Collaboration—the development of collaborative models and relationships with other agencies, groups, or any of those involved in early childhood services—is one of our main tools in

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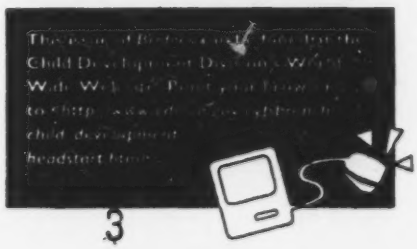

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Fostering Infant/Family Mental Health

by Penny Knapp, M.D., Medical Director, California Department of Mental Health

The term *infant mental health* refers to both early brain development and to attachment, encompassing biological, developmental, social–emotional, and relational elements, described as follows:

- *Biological.* This term refers to the optimum growth of a baby's brain. Related to that growth is the early, experience-dependent development of nerve connections within the brain, which are built in turn from connections made even earlier—*in utero*.
- *Developmental.* After an infant's birth, the direction for development is established through the parent/infant relationship.
- *Social–emotional.* This term refers to infants' and toddlers' sense of security and well-being, leading to their ability to trust others and acquire personal resilience.
- *Relational.* This term refers to the attachment theory, which describes the patterns of interaction between infants and their parents.

Clinical research has shown that if infant mental health is jeopardized or interfered with—for example, through early childhood neglect, abuse, malnutrition, or trauma—the following consequences occur:

1. *Biological and developmental.* The brain fails to develop fully. An example involving vision is the condition called *amblyopia*, which is a partial blindness resulting from poor visual fixation during the time the visual cortex is programmed. A hearing impairment during late infancy and early childhood results in deficient or delayed language development. Parallel developmental failure of emotional and cognitive functions is a consequence of interpersonal understimulation.
2. *Social–emotional and relational.* Infants who are traumatized or neglected are more likely than others to have lifelong psychiatric symptoms and lifelong difficulties with personal relationships, such as personality disorders or difficulty in controlling violent impulses.

Can we influence how the brain develops?

Recent brain research has demonstrated that 90 percent of the brain's growth occurs during the first five years of life and that brain growth is experience-dependent. This means that interpersonal, reciprocal, event-contingent interactions with a caregiver allow an infant to learn at his or her best. In other words, babies cannot learn from educational TV; they learn from the intimate give-and-take relationship with a real person who is paying attention to the baby's cues.

Obvious examples of poor conditions for brain growth are medical problems caused by factors that may include poor nourishment or premature birth, which jeopardize the development of the body, including the brain. The brain is, after all, the basic organ of adaptation to the environment. Adaptation to the environment shapes the brain throughout an individual's life, but does so particularly during the earliest stages of life. Brain growth during the first three years is crucial.

The brain forms itself in response to experience by replicating neurons, developing and selecting synapses, and organizing patterns of activation of neuronal impulses. Physical or experiential threats to optimal development at a very young age cannot be separated from outcome because the physical development of the brain is dependent on experience and vice versa. In planning for infant mental health, one must consider biological, psychological, and social risk factors and integrate interventions for all those factors.

How do relationships affect brain growth?

Brain growth requires more than just nutrition; it requires stimulation of the brain by experiences and interactions with the environment and with the persons who are caring for the infant. Infants are not all alike, no more than parents are. The crucial stimulating connection between mother (or father) and infant depends on how well they are able to coordinate their behaviors. This connection has been studied in infants at three, six, nine, and twelve months of age through an evaluation of mothers' and their babies' videotaped behavior and the synchrony of changes in their behavior with each other.

Even very young infants are capable of communication and emotional expressions that are quite organized. That capability may be the logical outcome of evolution, which, during harsher times, placed a premium for survival on newborn humans who were equipped to attach to a parent in an appealing way. When infant–parent interactions are regulated mutually, negative feelings, such as crying, are transformed into positive ones, such as comforting and cooing. Such small emotional recoveries build resilience and interpersonal sensitivity in the baby.

Conversely, babies who are left to cry to exhaustion, who rarely are able to bring forth a positive reaction from their parent, and who exist in an unpredictable or frightening social environment develop poor interpersonal abilities. Infants who have had blighted attachments go on to develop psychiatric syndromes in childhood. However, parents who have troubled attachments with their infant can be helped to correct their pattern of interaction. Diverse programs have successfully carried out early intervention, as described later in this article.

Social stimulation of an infant by a caregiver is essential to the infant's brain development. However, the stimulation must be attuned to the baby's readiness to respond. Overstimulated infants may cry excessively at first, then protect themselves from being overwhelmed by "shutting down." Understimulated infants will eventually "give up" and withdraw.

It is difficult or impossible, even with psychiatric treatment later, to make up for a serious lack of stimulation in the early months of life or repair damage done by dangerous or traumatic stimulation. Treatment of children with early damaging experience is long, costly, and likely to be ineffective.

Which babies need intervention?

Infants who are neglected or abused or who fail to form secure attachments are likely to lag behind in self-regulation, develop psychiatric symptoms, and become involved in the juvenile justice system. Developmentally unhealthy situations and sequences lead to poor development of the brain, and children in those situations are more likely to have learning difficulties.

Animal infants—as well as human infants—who begin life with normal brains but are then neglected also have problems with brain development. This fact has been demonstrated with animals reared in impoverished environments, such as small, bare cages. Those animals' brains are smaller and have fewer neurons than those of animals reared in adequate environments. Human infants who begin with normal brains but are then abused also have problems with brain development. Those babies may develop behavior disorders, conduct disorders, and, later, violent behaviors.

Developmentally unhealthy situations and sequences lead to poor development of the brain, and children in those situations are more likely to have learning difficulties.

Research has also shown that when attachment is allowed to occur in a positive way and good attachment is restored after a disruption, an infant's brain responds by beginning to develop well again, as a healthy adaptive organ should do. This response occurs because the impact of the mother–baby environment is powerful, affecting how the intricate circuitry of the brain is "wired." Because wiring continues throughout development, experience can be corrective, just as it can be damaging. Early intervention with a family in building relationships can dramatically improve a child's prospects and quality of life.

What does the Department of Mental Health plan to do?

The California Department of Mental Health has launched its Infant/Family Mental Health Initiative (IFMHI) to bring early intervention to children at risk. Building on an earlier educational program funded by the Department of Developmental Services, the IFMHI program, in cooperation with the California Early Intervention and Technical Assistance Network (CEITAN), has the following goals:

1. Conduct pilot integrated services for infants from birth to three years of age in mental health systems of care.
2. Adapt an infant diagnostic system, called "DC 0-3," for use in care settings alongside the current system, DSM-IV. This is because the current system does not offer detailed descriptions of infants' and very young children's problems.
3. Develop community education, technical assistance, and consultations on infant/family mental health.
4. Train new infant mental health interventionists.
5. Provide interagency and interdisciplinary collaboration.
6. Evaluate outcomes of the preceding goals 1 through 5.

What is infant intervention?

Infant intervention affects the ways in which parents shape their infant's experiences. The brain of an infant differentiates and elaborates nerve connections in response to experiences in the infant's family. If the infant's mental health is jeopardized or disrupted, the intervention should be carried out through the infant's relationship with his or her mothering figure, because it is within the interactions of that relationship that the infant's brain acquires the experience that shapes its growth and changes the direction of its development.

The intervention consultant influences that relationship in part by conveying to the parent information about the baby's development as well as by helping the mother observe her baby's reactions, respond to the baby's cues, and become curious about the reasons for the baby's behaviors. The interventionist is also trained to

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Mental Health Treatment Is for Babies, Toddlers, and Families Too

by Scott Berenson, LCSW, Associate Mental Health Specialist, California Department of Mental Health

Traditionally, mental health services were available to children only after they turned five and entered the public school system. Recent research suggests, however, that mental health intervention may be more effective if children receive such services before this age. Today, mental health services are available to preschool-aged children, including those in programs such as Head Start, serving three- to five-year-olds, and Early Head Start, serving children from birth to three years.

Staff of these programs are often the first to realize a need for mental health intervention for a child in their charge. They are also aware that the challenges facing the child or family may be addressed by county mental health services. For this reason these early childhood programs are essential sources of mental health referrals. But how is such a referral accomplished?

Every county in California is required to have an access number listed in the telephone directory for families of children who are eligible for Medi-Cal and who may need mental health treatment. Only a parent may make a *direct* phone referral for mental health treatment through the county access number. A teacher, however, may request a referral packet by fax or mail, and may return it by fax or mail, to request that the access team consider mental treatment for the child. The county access team worker must first determine whether the mental health needs of the child meet "medical necessity" criteria and whether the parent or guardian consents to the child's treatment. The criteria are fairly broad, so if you think the child or his or her family may need mental health assistance, make that referral and let the access team do its job.

Children (birth to three years) who are at risk of developmental disability are entitled to receive services through Part C of the Individuals with Disabilities Education Act (IDEA) if they have an individualized family service plan (IFSP), which may be contained in their Head Start cumulative file. This service is administered by the regional center in collaboration with the special education local plan area (SELPA). Family resource centers are also part of this program and may provide a local information and referral location.

WestEd, another agency, has a list of regional centers, SELPAs, and family resource centers in each area. WestEd may be reached at (800) 869-4337.

Services for children eligible under Part C of IDEA may continue under Part B of IDEA when the children reach three years of age. The IFSP may be submitted to the local school district staff as an application for services under Part B, which provides special education services for children from age three to twenty-two or high school graduation, whichever comes first. As part of the referral for a child's special education services, staff may request that the child's individualized education program (IEP) team refer the child to the county mental health department for a mental health assessment. This assessment determines whether a child needs mental health treatment to prepare him or her to benefit from special education. Under IDEA the referral to county mental health must be made by an IEP team, not a parent or teacher, and the mental health treatment must be for the student's educational benefit.

The California Department of Mental Health has found the research supporting the efficacy of early mental intervention so persuasive that it has sponsored the pilot program Infant Mental Health Initiative (IMHI) in four counties: Alameda, Fresno, Los Angeles, and Sacramento. The emphasis of this program is on helping the infant establish a healthy bond with his or her primary caregiver by providing home visitation, assessment of and services to at-risk families by county health nurses and social workers, child protective services, mental health services, and alcohol- and drug-treatment programs. Besides mental health assessment, other related services may include parent training, health screening, and alcohol and drug treatment.

Similar programs in other states have reduced juvenile crime, child abuse, residential placements, and psychiatric hospitalizations. The California county collaborators want to demonstrate similar positive results to the California Legislature so that funds for this program may be provided for other counties. Head Start staff can assist the pilot programs by referring families that they feel may benefit from an improved child–caregiver bond. Information on how to refer families to this program is available from any of the IMHI agencies in the four counties.

Proposition 10 has also provided state funds to counties for mental health consultation in preschools, including Head Start programs, or specific intervention with families and children. However, county plans differ. To find out what services are offered for children in your county, contact your local Proposition 10 committee.

The current interest in, and funding for, mental health services is unprecedented. Resources are now available to provide mental health intervention to young children as a result of the knowledge gained from research that this may be the most effective period to do so. However, still at odds with current research and funding is the image of a baby on a couch undergoing Freudian analysis. The common misperception that young children cannot possibly have mental health needs or benefit from mental health intervention prevents children from receiving referrals for services and effective early intervention. The challenge for all of us in early childhood programs is to change our way of thinking and doing business and to use these new resources to improve the lives of California's children and families.

County Mental Health Access Numbers

1. Alameda	(800) 491-9099; (510) 567-8100
2. Alpine	(800) 486-2163
3. Amador	(888) 310-6555; (209) 223-6412
4. Butte	(800) 334-6622; (530) 891-2810
5. Calaveras	(800) 499-3030; (209) 754-6525
6. Colusa	(888) 793-6580; (530) 458-0520; (800) 700-3577 (after hours)
7. Contra Costa	(888) 678-7277; (510) 313-6101
8. Del Norte	(888) 446-4408; (707) 464-7224
9. El Dorado	(800) 929-1955
10. Fresno	(800) 654-3937; (559) 488-2796; (559) 453-6616 (after 5 p.m.)
11. Glen	(800) 500-6582; (800) 700-3577 (after hours); (530) 934-6582
12. Humboldt	(888) 849-5728; (707) 268-2955
13. Imperial	(800) 817-5292; (760) 339-4501
14. Inyo	(800) 841-5011; (760) 873-6533
15. Kern	(800) 991-5272; (805) 868-6600
16. Kings	(800) 655-2553; (209) 582-4481 (Hanford); (209) 992-2111 (Corcoran); (209) 386-5222 (Avenal)
17. Lake	(800) 900-2075; (707) 263-2258; 911 (after hours)
18. Lassen	(888) 289-5004; (530) 251-8108
19. Los Angeles	(800) 854-7771
20. Madera	(888) 275-9779; (209) 675-7850
21. Marin	(888) 818-1115; (415) 499-4271
22. Mariposa	(800) 549-6741; (209) 966-2000
23. Mendocino	(800) 575-4357; (800) 555-5906; (707) 463-4303
24. Merced	(888) 334-0163; (209) 381-6800
25. Modoc	(800) 699-4880; (530) 233-6312
26. Mono	(800) 687-1101; (760) 934-8648; (800) 760-3577 (after hours)
27. Monterey	(888) 258-6029; (408) 755-4509
28. Napa	(800) 648-8650; (707) 259-8159
29. Nevada	(888) 801-1437; (530) 265-1437; (530) 265-5811 (24-hour crisis line)
30. Orange	(800) 723-8641
31. Placer	(800) 895-7479; (530) 889-6791
32. Plumas	(800) 757-7898; (530) 283-6307
33. Riverside	(800) 706-7500; (909) 358-4526
34. Sacramento	(888) 881-4881; (916) 875-1055
35. San Benito	(888) 636-4020; (408) 636-4020
36. San Bernardino	(888) 743-1478; (909) 381-2420; (888) 743-7481 (TDD)
37. San Diego	(800) 479-3339
38. San Francisco	(888) 246-3333; (415) 255-3737
39. San Joaquin	(888) 468-9370
40. San Luis Obispo	(800) 838-1381; (805) 781-4768
41. San Mateo	(800) 686-0101
42. Santa Barbara	(888) 868-1649; (805) 884-1639
43. Santa Clara	(800) 704-0900
44. Santa Cruz	(800) 952-2335
45. Shasta	(888) 385-5201; (530) 225-5200
46. Sierra	(888) 886-5401; (530) 886-5401
47. Siskiyou	(800) 842-8979; (530) 841-4100; (800) 452-3669 (after-hours crisis line)
48. Solano	(800) 547-0495
49. Sonoma	(800) 870-8786
50. Stanislaus	(888) 376-6246
51. Sutter/Yuba	(888) 923-3800; (530) 822-7200
52. Tehama	(800) 240-3208; (530) 527-5637
53. Trinity	(888) 624-5820; (530) 623-1362
54. Tulare	(800) 320-1616; (559) 737-4660
55. Tuolumne	(800) 630-1130; (800) 228-3592; (209) 533-3553
56. Ventura	(800) 671-0887
57. Yolo	(888) 965-6647; (530) 666-8630

Training, Technical Assistance, and Resources for Young Children with Mental Health and Behavioral Disorders

by Mary Anne Doan, Director, Quality Improvement Center for Disabilities Services

The Quality Improvement Center for Disabilities Services (QIC-DS) for Head Start and Early Head Start in Region IX (serving Arizona, California, Hawaii, Nevada, and the Outer Pacific) is often asked for help by programs that are working with infants, toddlers, and young children with mental health issues or those who have been diagnosed with behavioral disabilities. The QIC-DS training and technical assistance (T/TA) network also receives calls for help with children who exhibit challenging behavior in the classroom but who may need only a strong behavior management program. When the T/TA specialist goes to the program site to observe the child in question, the specialist frequently sees a typically developing child. The program staff are then referred to the appropriate resources to get the help they need.

Far more disturbing are the cries for help from parents, teachers, disabilities staff, and program directors who believe that the children they are concerned about may have a more serious problem, such as a behavioral disability or mental health developmental disorder. These calls are much more common today than in past years, especially as we develop a new understanding of the brain through current research and the factors that affect optimum infant development.

Children classified as having mental health developmental disorders of infancy and early childhood are (1) those who exhibit characteristics indicating that their behavioral or emotional development is at risk of further delay; (2) those who show a complexity of symptoms, which cause concern that they may have a behavioral or emotional disorder; or (3) those who clearly exhibit characteristics of such a predominant nature that they fall within one of the disorder categories defined in "Diagnostic Classification of Mental Health and Developmental Disorders," published by Zero to Three: The National Center for Clinical Infant Programs (now known as Zero to Three: The National Center for Infants, Toddlers, and Families). A few examples of these categories are as follows:

- *Traumatic stress disorder*, in which the child shows symptoms related to extreme stress or trauma

- *Disorders of affect*, in which the child exhibits symptoms related to anxiety, attachment, and mood disorders
- *Regulatory disorders*, in which the child has difficulty regulating physiological, sensory, attentional, motor, or affective (emotional) processes and which affect the child's daily adaptation, interactions, and relationships
- *Disorder of relating and communicating*, which traditionally includes *autism* and *pervasive developmental disorder* but may also involve other disorders in which the child exhibits difficulties in relating and communicating and may have multiple symptoms affecting several developmental systems, such as physiological, sensory, attentional, motor, cognitive, and affective experience

When staff suspect that they are observing a mental health or behavioral concern of a more serious nature in a young child, it is important that they call for additional resources and help. Early Head Start and Head Start programs in Region IX have both the QIC-DS at Sonoma State University and the Quality Improvement Center (QIC) at Developmental Associates as their primary resources for help on these issues. The following are some examples of the types of training and technical assistance that the QICs provide:

- Developmental Associates has on staff a mental health specialist to help programs with staff training, technical assistance, and the location of other resources for mental health disorders. In addition, the QIC has been providing workshops throughout Region IX on issues related to working with children exhibiting challenging behaviors.
- The QIC-DS has program specialists whose main focus is on children with *disabilities*—those being served in Head Start programs who have or are suspected of having a mental disability—and the services provided to them. The T/TA provided by a program specialist may include:
  - — Where to refer a child who might have such a disability
  - — Information on the types of screening and diagnostic tools to be used in diagnosing a child to comply with the Individuals with Disabilities Education Act (IDEA), Part C, Early Intervention Services (for children from birth to three years), or Part B, Special Education Services (for children three to five years old)

— Information on the types of programs available for on-site consultation or training
— Suggestions for the classroom teacher or disabilities coordinator to individualize the program for a child with a certain type of disability

The QIC or the QIC-DS may be called to make recommendations on-site, before or after a referral has been made, regarding adaptations in the classroom, program and management techniques, specific types of activities to use in the classroom, or curricula that may emphasize social and emotional development. In addition, the T/TA program specialists may suggest resources for staff development, reflective supervision, and ongoing mental health support for program staff that would help them in working with children who have significant mental health and behavioral disorders. QICs may also suggest resources on parent-support groups and networks for families of children with autism, pervasive developmental disorder, attachment disorder, or other types of disorders.

Both the QIC-DS and the QIC have resource libraries, which provide multimedia resources on infant mental health, behavioral disorders, screening and assessment, and related topics. A list of some of the recommended resources may be found at the end of this article.

Many other T/TA providers in Region IX also offer help and support through ongoing training programs, T/TA projects, workshops, mentoring and supervision of staff working with children who have significant mental health disorders, and other services. For example, the California Early Intervention Technical Assistance Network (CEITAN) offers training programs and several workshops on behavioral and mental health disorders, and the California Early Childhood Mental Health Work Group meets on a regular basis (see the resource list for details). Every state in Region IX has some focus on mental health development under IDEA, Part C, or the state-level Mental Health Agency.

Working with young children involves a relationship-based approach, and a child's development is affected daily by the interactions of the primary caregivers in that child's environment. When a child has a mental health or behavioral disorder, those issues cannot help but affect how the child relates to others and how others relate to him or her. So if you have any concerns about the emotional well-being of a child you are working with or parenting, or if you suspect that the child may have a mental health or behavioral disorder, it is important to remember that prevention is the key. Immediate referral, screening, and diagnosis are essential to an optimal intervention approach and prevention of further developmental risk or delay. The intervention approach may be developed with the help of the Disabilities Services staff at QIC-DS; QIC; IDEA, Part C or Part B, services; or other resources in your program and community.

So if you have any concerns about the emotional well-being of a child you are working with or parenting, or if you suspect that the child may have a mental health or behavioral disorder, it is important to remember that prevention is the key.

We at QIC-DS would be happy to help you in any way we can. You may reach us at:

Quality Improvement Center for Disabilities Services
California Institute on Human Services
Sonoma State University
1801 E. Cotati Ave.
Rohnert Park, CA 94928
(800) 625-7648

We hope that the following list of recommended resources will be of help to you:

California Early Intervention Technical Assistance Network (CEITAN)
429 J Street, Plaza Level
Sacramento, CA 95814
(916) 492-9999
Contact: Virginia Reynolds

CEITAN distributes a pamphlet titled *Relationship-Based Support Services for Babies with Special Needs and Their Parents* and the California Infant Mental Health Work Group's recommendations for screening, assessment, service delivery, and training to promote infant social and emotional/mental health.

Child Development Media, Inc.
5632 Van Nuys Boulevard, Suite 286
Van Nuys, CA 91401
(800) 405-8942

Child Development Media, Inc., offers information on infant mental health, including the videotape *Exploring First Feelings*.

Head Start Publications
1025 Vermont Avenue, NW,
Suite 1025
Washington, DC 20005
(202) 737-1030

Training guides for Head Start and other early education programs are available from Head Start Publications. Check with this organization regarding the availability of the newly developed guide *Supporting Children with Challenging Behaviors: Relationships Are Key*.

National Technical Assistance Center for Mental Health
Georgetown University Child Development Center
3307 M Street, NW, Suite 401
Washington, DC 20007
(202) 687-5000

The National Technical Assistance Center for Mental Health offers information on early childhood mental health consultation.

Zero to Three
National Center for Infants, Toddlers, and Families
734 15th Street, Suite 1000
Washington, DC 20005-1013
(800) 899-4301

Contact Zero to Three for resources on infant mental health, including the videotape *Reflective Supervision: A Relationship for Learning*, the journal *Zero to Three*, and the publication "Diagnostic Classification of Mental Health and Developmental Disorders."

Children with Challenging Behavior: Resources for Reflective Thinking

by Linda Brault, Project Director, Beginning Together, California Institute on Human Services, Sonoma State University; Mary Jeffers, Family Home Child Care Provider, Early Intervention Home Visitor, and Parent Educator; and Sandy Tucker, Community College Instructor and Program for Infant/ Toddler Caregivers (PITC) Certified Trainer

As early childhood professionals, we are seeing increasing numbers of children with challenging behavior. We worry about their social and emotional well-being, wonder about how to be effective, and wrestle with our reactions, judgments, and ability to support the children and families. While everyone is wishing for the one article or workshop to "make all the problems disappear," deep down we know that the solution lies in having access to tools and resources that can help us be more effective with the children, be respectful of the families, and prevent burnout for staff. This article offers some lessons learned as well as useful resources for those interested in more information. Some of the resources are described within the article. All resources are listed at the end of this article.

Who Challenges You?

Take a moment to think about a young child who drives you crazy. Jot down a few single words that describe that aspect of the child. Are the terms negative? Can you find a more positive (or at least neutral) counterpart? Mary Sheedy Kurcinka, author of *Raising Your Spirited Child*, has done extensive work on helping parents and professionals see that labels and descriptions of a child can dramatically change the way we relate to the child. By identifying the characteristic and providing a positive label, we can use "words that wrap our children in a protective coat of armor, giving them the strength they need to make the behavior changes that actually turn the inappropriate behavior into acceptable actions" (p. 22). *Raising Your Spirited Child* and the accompanying workbook are wonderful books for parents and professionals to read when first challenged by a child's behavior.

There are many reasons that a child may be regarded as challenging, such as a child's disability or temperament or reactions to situations at home. Also considered challenging are children who disrupt the status quo or children who "ruffle" your values. In addition, the way each adult in a child's life reacts to and interprets the behavior may contribute to the "challenging" label. Adults bring a strong sense of what children should and should not do. This sense comes from a combination of how you were raised, your cultural values, and your training. The best resources do not offer you a "cookbook" but rather a shift in the way you approach the challenge. It is helpful to begin with reflection because "what we think determines what we do" (quoted from the *Reframing Discipline* video).

Adults react emotionally to children's challenging behavior. We all have buttons that get pushed, and these are real buttons. Recent research on the brain allows us to picture the paths that the energy of a thought takes as it travels through the brain. This research is summarized in Daniel Goleman's book *Emotional Intelligence*. We now understand that, in a moment of crisis, the usual path is short-circuited and the thought energy can get stuck in a primitive part of the brain that triggers the flight, fight, or survival responses. Postponing action when this response is triggered by a challenge from a child allows time for that thought energy to reach the more developed part of the brain. This part of the brain can actually think about its own thinking, access all that it knows, and make choices about interpretations and actions.

Why Do Children Challenge Us?

Children challenge us in order to communicate their needs or goals. Children are people. They want the same things as the rest of us want: to belong, to feel significant, to accomplish, to satisfy desires, to be cherished. *The underlying goal of* all *behavior is to find a sense of belonging and significance.* Families, early childhood teachers, and child care providers are here to support children in their goals. This goal holds true for adults as well as for children. In group settings and in families, adults tend to emphasize the "belonging" aspect—fitting in to the whole—while young children are driven by their goal of feeling significant, unique. It may seem as though these goals are clashing when in fact they are two sides of the

same coin. Everyone has a need to belong by being valued for the unique person he or she is.

Behavior *is* communication. So what is the challenging child trying to tell us? Rudolf Dreikurs (quoted in Jane Nelson's *Positive Discipline*) says that there are four mistaken goals of behavior: attention, power, revenge, and assumed inadequacy. However, the underlying goal is always to belong and feel significant. Each of Jane Nelson's books on *Positive Discipline* has a chart with the mistaken goals, adult reactions, child reactions, and possible responses to the child's action that can encourage more appropriate behavior. Her books, Web site, newsletter, and workshops are an invaluable resource for anyone wanting to approach discipline in a respectful and positive manner. Many of the ideas shared in this article come directly from the work done by Dr. Nelson.

What Is Being Done?

Respect and developmentally appropriate practices must be the foundation of early child care. Many books and workshops are devoted to specific methods. Most people working in early childhood programs have access to many of these ideas, including various positive discipline techniques; sensory stimulation; expression of feeling through words, art, motion; teaching of social skills; routines and rhythms; smooth transitions; accommodation of physical needs; anticipating difficulties; and choosing battles. (See Selected Resources for basic information on managing behavior, especially the Council for Exceptional Children's *Practical Ideas for Addressing Challenging Behaviors*.) Yet it seems that everyone is looking for that one workshop or method that will address all of their concerns once and for all!

How Do We Respond?

At this point it may be enlightening for the teacher, parent, or child care provider to write down a few single words about how he or she feels when all these things have not worked. These words may give you a clue about the "mistaken goals" of the child (see *Positive Discipline* series). The words may also show you why many people give up at this point. We tend to react emotionally, not only "in the moment" but also over time to repeated failures, frustration, or lack of progress. This tendency may cause us to pull back and distance ourselves from the child when what we really need to be doing is getting more and more connected. (For more about the importance of establishing relationships with children to influence their behavior positively, see the second video in the *Reframing Discipline* series, *Connecting with Every Child.)*

Adults often *react* out of these feelings, causing them to miss opportunities to *act* out of a deeper understanding. They may use one technique exclusively, forget methods or techniques they have learned, or lose control. After a while the adult may decide that the child cannot remain in the setting any longer. Although changing settings may in fact be in the best interest of the child and teacher or caregiver, this decision must be reached only after careful consideration from a place of internal calm. Adults will then be able to support the child and parent in the transition to a new setting without guilt or blame.

What Do We Do Next? The Adult as Learner

We have challenged ourselves to move from the adult as teacher/facilitator to the adult as the learner and the child as the teacher. Our basic premise is that young children *have self-esteem, they have good intuition about their needs and feelings.* As adults one of our roles is to maintain children's self-esteem by respecting and interpreting what children communicate through language and behavior while supporting them as they tune in to their intuition, temperament, and feelings.

What most people want to change is the child (and/or the parent). We become frustrated when we realize that we usually cannot control either one. There are only two things we as teachers or caregivers can control: (1) our own behavior and interactions; and (2) the environment. The focus of our work is on the emotional and internal component of those two areas, becoming more reflective and responsive adults. We look for ways to build a healthy environment and, since the majority of communication between people is nonverbal, we look at modifying adult reactions to emotions and thought patterns. Changing *ourselves* in these ways may result in changed reactions from the child and/or parent. It is also important to examine where time and energy is spent in the classroom or group setting. Here are some ideas to assist adults in becoming more reflective.

Tools for Reflective Thinking

1. *Meeting children's emotional needs—an integral part of any curriculum.* We need to rethink how we structure and design our time with children. How much value do we place on the underlying goals of belonging and feeling significant? How often do we observe children carefully to see what they are interested in? The *Reframing Discipline* video series from EdPro is the best tool we have found that illustrates and reinforces being respectful of the children with challenging behavior while acknowledging the frustrations and needs of caregivers and teachers. (See Selected Resources for ordering information.) Although this video series is quite expensive, it is a tool that staff members can watch several times, learning something new each time.
2. *Problem solving as a tool for reflection.* Most people are familiar with some version of problem-solving steps; for example, (1) define the problem; (2) gather information; (3) partner with the parents; (4) generate as many solutions as possible; (5) choose one possible solution and make a plan; (6) implement the solution chosen; and (7) evaluate the solution. Such steps can be useful in developing a positive behavior plan. (See related articles in the Council for Exceptional Children's *Practical Ideas for Addressing Challenging Behaviors.*) We have found that doing some preliminary reflective steps can

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Children with Challenging Behavior: Resources for Reflective Thinking

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yield a more accurate definition of the problem (step 1). Our version of problem-solving steps can be found following the Selected Resources.

3. *Miss-takes versus mistakes.* Think again about how you feel about yourself when all of these techniques have not worked. The feeling and emotions themselves are neutral; however, they have often taken on negative meanings based on our life experiences, messages from other people, and so forth. We often experience strong emotions when interacting with a child we find challenging. How we react may cloud how we want to act. You can turn your mistakes into miss-takes by following what Jane Nelson calls the three "R's" of recovery (adapted from *Positive Discipline*):

   - RECOGNIZE
     Catch your internal messages, thoughts, feelings, and reactions.
   - RECONCILE
     Shift from the negative. There are many ways to do this. A few are as follows: recognize and replace the thought; let the thought go; analyze the thought; or let it run its course. An additional idea is to imagine the child as an adult looking back on the situation. What is the long-term view for this child? Can you reconcile your ideas with this "big picture"?
   - RESOLVE
     Wait for the "internal calm." Once this occurs, you are able to find other techniques. There are many "right" ways. You are an artist; be creative in your solutions.

How Can Administrators Support Reflective Practices?

Administrators are challenged to find the time, energy, and resources to use and support this reflective process with staff, children, and families. The process may include more planning time, in-service training, regular staff meetings, reflective supervision, and time for parent conferences. A parallel process occurs as we recognize and reflect. How we interact with each other influences how we interact with the children and with their families. Just as it is difficult to be effective with children without a relationship, administrators will find reflection more effective when they have taken the time to build a community within and around their organization.

Keep the goal as supporting the two needs of all people: (1) to belong, to fit in to the whole; and (2) to feel significant, to be unique.

How Do You Know If You Are Successful?

Initially, by looking at yourself in new ways, you may feel less successful. Do not be fooled, the success lies in the trying. Focus on small changes. Although the majority of your interactions will be positive, there are still going to be "miss-takes." Think of these as opportunities for learning. Do not make it your goal to decrease the number of "miss-takes." Keep the goal as supporting the two needs of all people: (1) to belong, to fit in to the whole; and (2) to feel significant, to be unique.

The challenging child accelerates our growth curve. Learning about another individual will never fail to teach you incredible things about yourself. Just think, this child who stumps you may take you where no one else can!

Selected Resources

Brazelton, T. Berry. 1992. *Touchpoints: Your Child's Emotional and Behavioral Development.* Reading, Mass.: Addison-Wesley Publishing.

Budd, Linda S. 1993. *Living with the Active Alert Child: Groundbreaking Strategies for Parents.* Seattle: Parenting Press, Inc.

Cherry, Clare. 1981. *Think of Something Quiet: A Guide for Achieving Serenity in Early Childhood Classrooms.* Carthage, Ill.: Fearon Teacher Aids.

Council for Exceptional Children, Division for Early Childhood. 1999. *Practical Ideas for Addressing Challenging Behaviors.* Monograph Series from *Young Exceptional Children.* Longmont, Colo.: Sopris West.

Crary, Elizabeth. 1993. *Without Spanking or Spoiling.* Seattle: Parenting Press.

Faber, Adele, and Elaine Mazlish. 1980. *How to Talk So Kids Will Listen and Listen So Kids Will Talk.* New York: Avon Books.

Faber, Adele, and Elaine Mazlish. 1987. *Siblings Without Rivalry.* New York: Avon Books.

Glenn, H. Stephen, and Jane Nelson. 1989. *Raising Self-Reliant Children in a Self-Indulgent World.* Rocklin, Calif.: Prima Publishing.

Goleman, Daniel. 1995. *Emotional Intelligence.* New York: Bantam Books.

Gonzalez-Mena, Janet. 1995. *Dragon Mom: Confessions of a Child Development Expert.* Napa, Calif.: Rattle OK Publications.

Greenspan, Stanley, and Jacqueline Salmon. 1995. *The Challenging Child: Understanding, Raising, and Enjoying the Five "Difficult" Types of Children.* Reading, Mass.: Addison-Wesley Publishing.

Kline, Peter. 1988. *The Everyday Genius: Restoring Children's Natural Joy of Learning—And Yours Too.* Arlington, Va.: Great Ocean Publishers.

Kurcinka, Mary Sheedy. 1991. *Raising Your Spirited Child.* New York: Harper Collins.

Lieberman, Alicia. 1995. *The Emotional Life of the Toddler.* New York: Free Press.

Nelson, Jane. 1996. *Positive Discipline.* New York: Ballantine Books.

Nelson, Jane. 1997. *Understanding: Eliminating Stress and Finding Serenity in Life and Relationships.* Rocklin, Calif.: Prima Publishing.

Nelson, Jane. 1999. *Positive Time Out.* Rocklin, Calif.: Prima Publishing.

Reframing Discipline. Video series. For more information, contact Educational Productions, telephone 1-800-950-4949; Web site http://www.edpro.com.

Tureki, Stanley. 1989. *The Difficult Child.* New York: Bantam Books.

Weinhaus, Evonne, and Karen Friedman. 1991. *Stop Struggling with Your Child.* New York: Harper Collins.

Problem-Solving Steps as a Tool for Reflective Thinking About Children with Challenging Behavior

Most outlines of problem solving use similar steps. The following process was adapted from a workshop given by Joanne Dugger, Child Development Instructor, at the San Diego Association for the Education of Young Children Conference in fall of 1995. Additional ideas have been added by Mary Jeffers. These steps, taken in the order given, work together to help caregivers address challenging behavior thoughtfully.

Preliminary Steps—Essential for True Reflection

1. **Recognize and clarify your own feelings.**

   Take ownership of your emotions.

   Understand your reactions.

   Be self-aware: What is your emotion, and what is your reaction telling you?

   Use centering/focusing techniques as needed to release your emotional energy.

2. **Recognize and clarify your perceptions of the feelings of the others involved—the child, other children, the parents, and other staff.**

   Try to understand the person's emotions and reactions.

   What is the child trying to communicate through his or her behavior?

   Try to understand the person's stress.

   Be aware of judging or labeling the person's words and actions.

   Keep these things in mind as you begin the problem-solving process.

3. **Clarify the critical issues: What are the long-term, "big picture" lessons we need to share with children to make a difference in their lives?**

   Imagine the child as an adult looking back on the situation. What are the "big lessons" that need teaching? What will this child need to know in order to be a contented, contributing, connected adult?

   Note that this is hard work and requires personal introspection as well as staff discussion. Look at situations that are challenging. For example, is standing in line a critical issue? Why? Is standing in line the real issue? Are there underlying issues? To whom is it important?

4. **Build on strengths and be open to learning.**

   Whether thinking of the child, the parent, or yourself, identify and keep in the forefront the strengths of the situation and relationships of each person.

   Welcome the bumps and obstacles as learning experiences for everyone and recognize that this kind of learning may be more valuable than formal or planned lessons.

   Leave "room" for the disorderly and unexpected—unforeseen developments can bring the greatest gifts.

Problem-Solving Steps

1. **Define the problem; it will become a project!**

   Keep the statement of the problem simple and clear.

   Define *your* perception of the problem.

   A *person* is not the problem, the *problem* is the problem. Blaming the child, the parent, or the teacher distracts from the important task of identifying the real problem.

   If blame is still being projected, you need to go back and clear your emotions.

2. **Gather information.**

   Find out how often, when, where, why, who, and other data.

   Be sure to determine who "owns" the problem.

   If the problem, as you have defined it, is not owned by you, go back and redefine it.

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Web Site Resources on Behavior

The following web sites, many of which provide links to other related sites, may be of interest to parents and professionals. The descriptions of these web sites are taken from the sites themselves and are not offered with any official endorsement.

Positive Discipline

http://www.positivediscipline.com/

Positive Discipline is dedicated to providing education and resources that promote and encourage the ongoing development of life skills and respectful relationships in family, school, business, and community systems. This site features information and articles from Jane Nelson, author of *Positive Discipline* and other books.

The Preventive Ounce

http://www.preventiveoz.org/

This interactive Web site lets you see more clearly your child's temperament and find parenting tactics that work for your child. Developed by the Preventive Ounce over the past ten years, this program has been used by more than 20,000 parents in health maintenance organizations in the western United States. Outcome studies show that parents who use this service avoid the anxiety, frustration, and guilt that come when they cannot understand why their child acts "that way." They also avoid escalations into behavioral problems, conflicts with spouses and relatives, and unnecessary doctor visits. As a community service, this preventive program is now offered free to all parents.

Effective Behavior Support

http://brt.uoregon.edu/ebs/

The Effective Behavior Support approach provides a process and structure for enhancing the adoption and sustained use of research-validated schoolwide discipline practices. Effective Behavior Support is supported in part through a federal grant awarded by the Office of Special Education Programs, U.S. Department of Education.

CHADD—Children and Adults with Attention-Deficit/ Hyperactivity Disorder

http://www.chadd.org

Attention deficit disorder, attention-deficit/hyperactivity disorder, ADD, AD/HD—there are nearly as many names for the disorder as there are opinions about its diagnosis and treatment. That's why there's CHADD, the national nonprofit organization representing children and adults with attention-deficit/hyperactivity disorder (AD/HD). Founded in 1987 by a group of concerned parents, CHADD works to improve the lives of people with AD/HD through education, advocacy, and support. Working closely with leaders in the field of AD/HD research, diagnosis, and treatment, CHADD offers its members and the public information they can trust.

Regional Intervention Program

http://members.aol.com/RIPNASHTN/index.html

The Regional Intervention Program (RIP) has been serving families with young children since 1969. RIP is an internationally recognized, parent-implemented program in which parents learn to work directly with their children. Experienced RIP parents provide training and support to newly enrolled families. The program is available to families who have concerns regarding a young child's behavior and is coordinated by a professional resource staff person.

Research and Training Center on Family Support and Children's Mental Health

http://www.rtc.pdx.edu/

The center was established in 1984 at Portland State University in Portland, Oregon. The center's activities focus on improving services to families whose children have mental, emotional, or behavioral disorders through a set of related research and training programs. The training program includes a variety of activities, including the center's annual Building on Family Strengths family research conference. There is also a newsletter called *Focal Point* available to any interested persons. (Information is on the Web site.)

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

http://www.mentalhealth.org/child/index.htm

Caring for every child's mental health, Communities Together is a national public education campaign emphasizing the need for attention to children's and adolescents' mental health. It supports the Comprehensive Community Mental Health Services Program with 29 sites in 18 states demonstrating effective services. This public/private sector campaign is managed by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Comprehensive Community Mental Health Services for Children and Their Families Program

http://www.air-dc.org/cecp/promisingpractices/

The Promising Practices Mini-Web offers information on what's working for children with serious emotional disturbance in systems of care. At this site you can find seven monographs on promising practices in children's mental health.

A Place for Us . . . Oppositional Defiant Disorders Support Group

http://www.conductdisorders.com/

If you'd like to hear from some families whose child has one of the many defiant disorders, read families' stories, and learn about things that have worked or have not worked, you can browse this Web site. Stories are grouped by age categories to help you narrow your search to meet your own needs.

Child Care Mental Health Consultation: A Relationship-Based Model

by Jennifer Smith, Project Coordinator
Child Care Mental Health Project,
Childcare Health Program

Child care mental health consultation provides support to child care providers by offering them a broader context for understanding children's behavior and family dynamics and more comprehensive and effective strategies for working with children and their families. Several programs around the country have been providing such services to child care programs for some time.

For consultation services to be effective and meaningful, child care mental health consultants must establish a relationship-based consultation model that serves as a parallel process for the development of positive, mutually respectful, reciprocal, trusting, and responsive relationships with child care providers. The providers, in turn, may develop these types of relationships with the children in their care and their families. When consultants build rapport and establish trust with child care providers, the consultants optimize the care staff's willingness to accept an on-site consultant and to develop a collaborative partnership.

Relationships Are the Key

Various models of consultation have been helpful. However, the Child Care Mental Health Project believes that a relationship-based approach to mental health consultation is the most effective. Why?

When you improve the relationships among and between all the important caregivers in a child's life, you have a direct, positive impact on the child. Relationships are the cornerstones of young children's development. As research on the brain highlights, children's social and emotional development and their experiences in relationships and of "self" in the world affect all other aspects of their development. Through these early relationships children develop their sense of how to interact and to relate with others—responses that help them throughout their lives.

Child Care Providers Need Support and Training

The current state of child care shows the need to provide supportive consultancy to child care providers. Mental health consultants bring clinical expertise into the child care setting and help the care providers to deal with the growing numbers of very young children in their care who come from homes with complicated and complex family issues. Many of these children are in group care for up to ten hours a day, five days a week. However, for care providers to be receptive to this clinical expertise, the mental health consultants must establish consultant-provider relationships based on trust and respect, which develop over time. Only then can providers begin to integrate different views of children's behavior. With additional information and support from the mental health consultants, the providers' overwhelmingly high levels of stress decrease, increasing the likelihood of providers remaining in child care. In addition to stress, child care staff are underpaid, leading to high turnover rates that are fueling the crisis in child care today.

Relationship-Based Models Maximize Services

These services cast the widest net. Traditional therapeutic models assist individual children and their families and affect only a limited number of children. They provide consulting services only for children who are identified and diagnosed as needing intervention. More beneficial is a consulting model that considers all children in a program—that all may benefit from mental health consultation. It addresses both the programmatic and environmental issues that may be affecting children's and staff's behavior. The primary focus of intervention is systems-based. However, this model does not preclude or replace therapeutic interventions, which should be available for children and their families when needed and when determined appropriate.

Change must come from within the system. Changing the child care system from within, through the child care providers themselves, makes for the most permanent, effective change. Such

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Parents Place, Jewish Family and Children's Services, and Day Care Consultants, Infant Parent Program, Collaborate on Early Childhood Mental Health Consultation Model

by Laurel Kloomok, Director, Parents Place, and Kadija Johnston, Director, Day Care Consultants

To meet the growing need for quality child care and to ensure quality service by caregivers, the Parents Place (a program of the Jewish Family and Children's Services in San Francisco, Sonoma, Marin, and the Peninsula) and the Day Care Consultants (a program of the Infant Parent Program, University of California, San Francisco) have collaborated to provide an early childhood mental health consultation model service through the Early Childhood Mental Health Services Project (ECMHSP). The tremendous social shift in the care of this nation's very young children from the family to child care providers has risen by 50 percent over the past three decades. More than five million children under age three are now in the care of adults other than their parents. In California alone there are more than 41,000 licensed family child care homes.

Decades of research have affirmed that the environments, early experiences, and relationships of infants and young children are the forces that form children's sense of themselves and of the world and affect how those children will manage their lives at school age and beyond. Quality child care ensures provision of developmentally enhancing experiences for children in care, promotion of their wellness and mental health, identification of their needs, demonstration of appropriate responses to the children's needs, and availability of early intervention to those whose developmental and emotional problems might otherwise go undetected until school age. However, not all child care providers have the knowledge, training, ability, and support to provide quality child care. Some are ill equipped to handle a challenging child who exhibits emotional, behavioral, developmental, or social difficulties that may be caused by stressors such as economic deprivation, parents with mental health and alcohol/substance use disorders, homelessness, experiences of community violence, and lack of loving and caring relationships. When caregivers fail to respond appropriately to a child's challenging behavior with calm, firmness, and empathy, the caregivers are more likely to compound the child's difficulties. This failure to respond only reinforces the child's feelings of hopelessness and incapability, belief that the world is dangerous, and fears that adults are unlikely to help.

The tremendous social shift in the care of this nation's very young children from the family to child care providers has risen by 50 percent over the past three decades.

We in the child care community are concerned that the quality of child care may not be in keeping with the new status of child care as a *growth industry*. To handle the issue of quality, we provide training and consultation services needed by child care providers through the ECMHSP.

Training

The mental health consultants of ECMHSP train child care providers to develop their abilities and skills to enable them to:

- Offer healthy, safe, and developmentally appropriate and growth-promoting experiences for children in their care.
- Respond appropriately to the children's needs and to the multiple emotional, behavioral, developmental, and social challenges exhibited by the children in their care, especially those who live in poverty and with families who are struggling for economic survival.
- Develop good and positive relationships with the children in their care to alleviate the difficulties children may face and the effects of stressors on children—increasing the children's resiliency.
- Increase their awareness and understanding of the impact and importance of their interactions with children.

Children develop best in a child care setting that promotes a good relationship between the child and the child care provider (parallel to a positive relationship between child and parent). Indeed, the central concern of mental health consultation must be this relationship. But while we make training and consultancy readily available, past experiences of mental health consultants have taught us that most caregivers initially seek consultancy services only when they are especially worried, alarmed, or frustrated by the behavior of an individual child. Often, challenging and difficult children resist even good relationships and growth-promoting experiences offered in child care. Usually, providers are driven to seek consultancy help only when they feel desperate. Otherwise they might not feel the need for it, especially if they are concerned about how people, including the consultant, may regard their inability to solve the problem independently. The providers may feel that the consultant's usefulness is limited only to those particularly acute and crisis situations.

Consultancy

While the goal of mental health consultation is to improve the quality of care for all children in a program, the first step in the process is to respond to a provider's or staff's immediate need about a particular child. The consultant's initial concerned response to this need forms the basis of a consultant-provider relationship. When the

consultant exhibits empathy, the provider begins to feel that the consultant understands not only the experiences and feelings of a particularly difficult child but also those of his or her own stresses, feelings, and experiences with the troubled child. The provider then begins to develop trust in the consultant, in the consultant's general expertise on child-provider interactions and, eventually, in the consultation process as a whole.

Several factors determine the success of consultation, but the more important ones are as follows:

— **Establishment of a positive consultant-provider relationship that paves the way for a learning alliance.** This relationship occurs over time and builds up as mutual trust and respect between the consultant and the provider are developed. The provider's readiness to engage in the learning process is established, and the provider gains perspective of his or her own responses. The learning alliance enables the consultant and the provider to work effectively together in understanding the needs of children in care centers and how best to meet them.

— **Respect for the provider, the children, and their families.** The consultant recognizes that those requesting the consulting service determine the course that each particular consultant arrangement takes. The consultant involves the provider in seeking the parents' permission, cooperation, and involvement in the process before any consultation begins about a particular child.

Providers begin to realize that mental health consultation not only is useful to the understanding of a troubled child in a crisis situation but also benefits the whole child care center.

— **Reduction of the provider's anxiety and self-doubt.** Reducing anxiety and self-doubt not only promotes the relationship between consultant and provider but also often removes obstacles to the provider's work with the troubled child and his or her family. Staff members are able to recover their ability to respond empathically and skillfully to the troubled child.

— **Provision of sensitively timed instructional information and materials on child development and mental health.** The consultant offers information and an appraisal of the child, developed through his or her observations of the child and interactions with the child's family, However, the consultant's didactic information and instructional materials can become useful and effective only if a consultant-provider relationship based on trust and respect has been established and the provider's anxiety has been reduced. Even the most brilliant advice can be burdensome to a provider who feels overwhelmed and distraught.

The benefits gained from mental health consultation for a troubled child are often the precursors of meeting the goal of improving the quality of all the child care center's services. Providers begin to realize that mental health consultation not only is useful to the understanding of a troubled child in a crisis situation but also benefits the whole child care center. This realization often leads to requests for general program consultation and results in improving the quality of the entire program.

For more information about the Early Childhood Mental Health Services Project, please contact Laurel Kloomok, Director of Parents Place, at telephone (415) 563-1041; e-mail: LaurelK@jfcs.org.

BRIDGES

Bridges is produced by the California Head Start-State Collaboration Office (CHSSCO), which was created to promote partnerships between Head Start and the larger child care and development community at the state and local levels. *Bridges* is funded by the U.S. Department of Health and Human Services, Administration for Children and Families, and the California Department of Education, Child Development Division. The opinions expressed are those of the authors and not necessarily those of the Department. CHSSCO is located in the Child Development Division, 560 J Street, Suite 220, Sacramento, CA 95814.

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News from the California Head Start Association

(Continued from page 1)

addressing the challenges brought by change and in successfully meeting the needs of the families we serve. To encourage wider participation and inclusiveness, CHSA will disseminate a variety of information through mass mailings, conferences, trainings, and its Web site: <www.ca-headstart.org>. The Web site, our newest endeavor, is an easily accessible base of knowledge and a forum for the sharing of thoughts and ideas.

To ensure the continued success, growth, and quality of the services provided to the families of California by Head Start and Early Head Start programs, we, as administrators, parents, and supporters of these programs, have to recognize that these challenges may best be met by working together and speaking out with a unified voice for the children and families we serve.

Finally, I encourage you to join the members of CHSA in this collaborative effort. Add your voice. Be informed of the task we face and become a Head Start and early childhood education advocate. Participate.

Sincerely,
Raymond Hernandez
CHSA President

BEST COPY AVAILABLE

Project Relationship: Creating and Sustaining a Nurturing Community

by Pamm Shaw and Carol Cole

"Her eyes seem vacant."

"His behavior is totally unpredictable."

"I didn't know what to do to help."

Sad eyes, angry outbursts, tears that fall too quickly, hungry looks that have nothing to do with a meal—all can be seen in the faces of many children in child care and development programs throughout the state. They are young children, only two or three years old, who may have been expelled from their community programs because they do not "fit in." To reach out to those children, the Los Angeles Unified School District has developed Project Relationship.

Project Relationship is based on the premise that respectful, responsive interactions among staff, families, and children are necessary to create and sustain early childhood programs that nurture the children. The project also holds that (1) each child care program is unique; (2) all behavior is communication; (3) adults are not interchangeable; and (4) the quality of relationships within the program is dependent on respect for individual differences and responsiveness to individual needs.

The project's basic tool is "Going Around the Circle," a structured, relationship-based framework for problem solving among staff to help them work together to nurture each child, even the children with the most challenging behaviors. This process is unique in that it promotes relationship-based services to children through relationship-based support to staff. Its strength is that it fosters inquiry, respect, and reflection, which can be achieved when participants build on the values, beliefs, cultures, experiences, and individual learning styles of staff members.

Materials used in the project include a training guide and video that illustrate the following components:

- *Improving Staff Communication*, which helps staff build authentic relationships to improve communication through mutual trust and commitment to the process
- *Enhancing Success for Young Children in Group Settings*, which demonstrates the importance of increasing personalized interactions between staff and children as well as among staff members
- *Enriching Program Practices for Children, Staff, and Families*, which shows how developing supportive routines and rituals can enrich program practices

Although project materials can be very useful in staff development, it is our belief that there are no "quick fixes" for building trust and relationships that prepare and support staff to work more effectively with children and families—especially those with special needs. Step by step, Project Relationship's trained facilitators build environments of trust and respect so that varying opinions, feelings, and levels of expertise can be shared in an authentic manner, which requires a long-term commitment.

Project Relationship is based on the premise that respectful, responsive interactions among staff, families, and children are necessary to create and sustain early childhood programs that nurture the children.

The quality of the care children receive is dependent on the preparation and support of the child care staff who interact with the children daily. The faces we see in child care *can* reflect trust and happiness. When children are safe and feel secure, they can explore their world, questioning and learning from all of their experiences. And the way we treat the children in our care—as well as the way we treat one another—is the way in which they will learn to treat others. If children do not receive love and support and do not develop trust, they will not acquire those crucial attributes.

Project Relationship training, ongoing support, technical assistance options, and training materials are available from WestEd Center for Prevention and Early Intervention, 429 J Street, Sacramento, CA 95814; telephone 916-492-9999; FAX 916-492-9995; e-mail: ceitan@wested.org.

Responsive Teaching: Nurturing and Supporting Children's Social and Emotional Development

by Deborah Conn

Each day in America, 13 million children under age six spend time with a caregiver or someone other than their parents, according to the Children's Defense Fund. As the number of children placed in out-of-home child care and early education programs continues to increase, we must answer this question: How can early care providers and educators best support children's healthy social and emotional development?

Unfortunately, most of the scientific and popular literature written about teacher-child interactions focus on learning outcomes, not on children's emotional or social development. Likewise, well-known assessment instruments (e.g., NAEYC Accreditation, Early Childhood Environmental Rating Scale, Child Development Associate, California Department of Education's *Program Quality Review*, and Head Start's federal monitoring instrument), designed to evaluate program quality or teacher competency or both, focus primarily on physical environment, curriculum, and program management. Consequently, early childhood programs have limited guidance and resources for training and evaluating teachers in the areas of children's social and emotional development.

This article is a first step to filling this void. It is based on the result of a four-year observation and study of responsive teachers—those skilled in supporting children's social and emotional development. The study answers two important questions:

1. What are the qualities and behaviors that make teachers responsive?
2. How do we help teachers develop and improve those qualities and behaviors?

Responsive teaching is the teacher's actions and use of language that nurture and support all children, including those with special needs and challenging behaviors. It is based on the knowledge and understanding that behavior is meaningful, is learned from those surrounding us, is significantly influenced by the environment, and can be changed. The guiding principles of responsive teaching include unconditional positive regard for the child, respect for and acceptance of individual ideas and feelings, acceptance of diversity and individual uniqueness, adoption of developmentally and individually appropriate practices, and development of self-awareness through reflective practices.

Qualities and Attributes of Responsive Teachers

Responsive teachers have the following common major qualities and attributes:

- *Ability to develop trust.* The primary goal of responsive teaching is to develop in each child a sense of trust that lays the foundation of secure attachments and reciprocal relationships. Responsive teachers build trust by relating empathically with the children, providing stable environments through consistent routines and practices, and by following through on their commitments to the children.
- *Ability to take the child's point of view.* A defining skill that makes the responsive teachers exceptional is their ability to take the child's point of view. This ability goes beyond empathy, which is defined as compassion and caring. It is the ability to understand how children are feeling and why they are behaving in a particular way. Responsive teachers understand that all behavior is meaningful, but knowing that each child is different, they make sure that they do not fall prey to stereotypes and jump to conclusions. They take time to observe the children closely, gather information from parents and others, draw conclusions, and test them out. Once they know a child well, they almost instinctively know how the child will behave and why.

  In a recent interview with two of these special teachers, each was asked how they were able to take the child's point of view. One teacher responded by saying she had learned how to truly observe children. The other teacher felt it was because she had close bonds with the children in her class and was in tune with them. For both teachers it came down to knowing the children very well.
- *Ability to provide developmentally and individually appropriate activities.* Responsive teachers take the individual interests of the children and fit the activities accordingly. They use curriculum models that nurture and support not only the children's learning processes but also their social, emotional, and physical development. Noncompetitive activities, nonviolent materials, an antibias philosophy, and activities that include all the children are incorporated throughout the curriculum. The responsive teachers also know the significance of children's play and how to guide it to support the children's social and emotional development.
- *Knowledge and understanding of children's social and emotional development and what affects the children.*
- *Knowledge of how environmental factors affect children.*
- *Understanding of and respect for cultural diversity.* Responsive teachers gain competence in dealing with multicultural differences and beliefs. They make sure that furnishings, materials, books, and artwork reflect the culture and ethnicity of all families.
- *Responsive communication.* This communication involves both the verbal language and the nonverbal communication. When others are

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Providing Early Intervention Services to Young Children with Behavior Problems

by Kat Lowrance, Disabilities Program Specialist, Shasta Head Start, and Early Head Start Disability Consultant

According to early childhood teachers across the state, children with behavioral problems tend to be the most problematic in classroom environments.

Maintaining good class management and developing positive relationships with children and their parents depend largely on the proper ratio of adults to children. A Head Start classroom generally has 17 to 20 children (including children with disabilities who may have the opportunity to be included in the classrooms) with a teacher and an associate teacher. Occasionally, a parent or community volunteer or both are also present in the classroom.

Maintaining good class management and developing positive relationships with children and their parents depend largely on the proper ratio of adults to children.

Teachers usually call for professional help when a child acts out behaviorally. The child may have excessive tantrums, hurt others, or refuse to comply with the teacher's requests. This child is often far more of a challenge than is a child with a mild or moderate disability.

Identifying Process

Shasta Head Start, which serves three counties, has 560 three- to four-year-old children in its Head Start program and 180 children from birth to three years in its Early Head Start program. It has developed a process for identifying and serving children with behavioral problems. Services primarily target those children who would not qualify for other special education services. Teaching staff are trained to make modifications in the environment, interactions, and materials to deal with these children. When behavioral problems persist, the staff makes referrals to the Health and Disabilities Department.

Referral: Child Study Team

It is crucial to involve the family members in the intervention process, starting with their signature on the referral form. A child study team is then formed, made up of a representative from the Health and Disabilities Department, the teacher or home visitor, the family worker, and the members of the child's family. A team meeting is scheduled and conducted in a small group setting before the child has been identified as needing an assessment. A designated facilitator writes all information discussed on large sheets of easel paper to enable all participants to keep track of the discussion, which is conducted in the following order:

- The study team first identifies the strengths and interests of the child—an important step that allows the family to relax in what might be construed as a tense situation. When the family is relaxed, participation increases.
- All factual information about the child and family is noted: pertinent birth history, health history, place in the family (e.g., youngest of three), and other related information, such as foster home placement, prior or current help from Child Protective Services, and family stressors affecting the child.
- Teachers and family members talk freely about their concerns regarding the child.
- The teachers discuss the modifications they have tried in the classroom to alleviate the child's behavior, noting what worked and what did not. Family members help by discussing modifications they have tried.
- Using all this information, the study team designs a plan, taking into account who will do what and when.
- A follow-up meeting is scheduled to ensure the child's progress and allow the team members to make any changes that may be necessary in their plan. If assessment is a part of the plan, an individualized education program (IEP) for the child will be developed at the meeting.

Assessment Process: Multidisciplinary Team

The identifying process may include a multidisciplinary team assessment of the child. If such an assessment is designated and the family signs its permission, the child study team works with the multidisciplinary team to

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Providing Early Intervention Services to Young Children with Behavior Problems

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develop an assessment plan. The multidisciplinary assessment team includes a registered nurse, a licensed mental health consultant, early childhood professionals, family members, a nutritionist, and, when indicated, an occupational therapist. The nurse and the child's family investigate possible physical factors and consider any nutritional needs. The mental health consultant observes the child in both the classroom and the home setting, taking time to observe the child's relationship with his or her family. If a motor planning or motor coordination problem is indicated, then an occupational therapist becomes a member of the assessment team.

The IEP meeting is held within thirty days after the parent has signed permission to develop the assessment plan. Present at the IEP meeting are the assessment team members and all others who took part in the assessment—the family, the teaching staff, and the Disabilities Program Specialist.

The mental health consultant observes the child in both the classroom and the home setting, taking time to observe the child's relationship with his or her family.

Program Plan: Behavior Coach

Quite often, the child study team plan or IEP specifies the need for a behavior coach, who is hired specifically for the child. A three-stage coaching strategy is implemented as follows:

- *First* or *intense stage.* The behavior coach becomes the child's shadow and does not allow the child to engage in any aggressive behavior. The coach is there to teach the child alternate behavior for getting his or her needs met and to teach the child socialization skills.
- *Second stage.* The child begins to initiate the behavior on his or her own, and the coach begins to retreat, allowing the teachers to take over interactions with the child.
- *Third stage.* The child is able to make appropriate choices *most* of the time No three- or four-year-old child makes appropriate choices 100 percent of the time, and children with behavior difficulties cannot be expected to do so either.

The behavior coach works himself or herself out of the position The coach's placement with a child is meant to be a temporary position, as the goal is for the child to learn to socialize appropriately on his or her own.

The philosophy of early intervention is working for children with behavioral problems, and family participation is always a critical ingredient for its success. When success is achieved, the children and families thrive and grow.

Foundation Grants Support Child Care Capacity Building Project: Working with the Faith Community

With generous grants from the Packard Foundation and The California Endowment, the California Council of Churches has embarked jointly with Catholic Charities of California on a three-year project to expand the quality and quantity of child care services in California. Six counties were chosen for this outreach effort: Fresno, Los Angeles, Monterey, San Bernardino, San Joaquin, and Santa Clara.

Approximately one out of every four child care centers in California is either sponsored by or housed in a congregation. Buildir g on that base of involvement, field staff will offer congregations in particularly high-need areas the opportunity to assess their capacity to meet the pressing need for more child care services. Staff will also introduce those congregations to community resources and potential community partners to help them achieve their expansion goals.

Approximately one out of every four child care centers in California is either sponsored by or housed in a congregation.

Many congregations have already forged strong partnerships with Head Start programs. We want to encourage others to consider such partnerships as models and create new ways of working together to meet the child care and development needs of low-income families who must work outside the home.

While our outreach efforts will be focused on these six counties, anyone can request assistance in exploring community services with regard to child care by contacting Virginia Greenwald, statewide project coordinator for child care, California Council of Churches, 2700 L Street, Sacramento, CA 95816; telephone (916) 442-5447; e-mail: virginia@calchurches.org. For more information about this project, visit the Council's Web site, *<www.calchurches.org>*, and click on the Child Care Project Web page.

HEALTHY FAMILIES & MEDI-CAL FOR CHILDREN

INSURING THE HEALTH OF OUR CHILDREN

Over 1.2 million uninsured children qualify for the Healthy Families program or Medi-Cal for Children. A joint mail-in application is available in 11 languages.

BENEFITS:

- Regular checkups (including well-child visits)
- Immunizations
- Prescription medicine
- Lab and x-rays
- Dental and eye care (including eyeglasses)
- Mental health and substance abuse services
- Physician and hospital services

ELIGIBILITY:

- Determined by family income and size, and by age of the child*
- Covers children from birth up to age 19
- Available to U.S. citizens, U.S. nationals, and qualified immigrant children regardless of date of entry (a child may qualify for some form of Medi-Cal regardless of immigration status)

**Children whose family income is up to 250% of the federal income guidelines may qualify for one of these programs. For a family of four, that translates to $42,636/year (effective April 2000–March 2001).*

MEDI-CAL FOR CHILDREN

- No-cost coverage
- No monthly premiums
- No co-payments for any benefit
- Provides health, dental, and vision care coverage

HEALTHY FAMILIES

- Low-cost coverage for children who do not qualify for Medi-Cal
- Low monthly premiums from $4 per child to a maximum of $27 per family
- No co-payment for preventive services, such as immunizations
- $5 co-payment for non-preventive services, such as going to the doctor because of illness
- Choice of over 30 major health, dental, and vision insurance plans statewide

FOR MORE INFORMATION

1-888-747-1222

OTHER OPTIONS FOR CHILDREN WHO DO NOT QUALIFY FOR HEALTHY FAMILIES OR MEDI-CAL FOR CHILDREN:

*KAISER PERMANENTE CARES FOR KIDS** provides low-cost health care coverage for uninsured children who are not eligible for no-cost Medi-Cal for Children or Healthy Families. This program covers children under age 19 within Kaiser Permanente's California service area. For more information, call toll-free (800) 255-5053.

*CALIFORNIA KIDS** provides affordable preventive and primary health, dental, vision, and behavioral health coverage for undocumented children. For more information, call (818) 461-1400.

**Not affiliated with or endorsed by the State of California. Eligibility is based on family size and income.*

School Health Connections
714 P Street, Room 750, Sacramento, CA 95814; (916) 653-7746; FAX (916) 653-2781

Outreach Tips to Get Involved!

1. Inform parents about Healthy Families, Medi-Cal for Children, and other affordable health coverage programs:

★ **Display health care coverage information and referral numbers:**

- ♥ On bulletin boards
- ♥ In locations where parents may be present

★ Distribute information to parents:

- ♥ At open houses and school health fairs
- ♥ In newsletters

2. Inform staff on available coverage. Include:

- ♥ Teachers
- ♥ Office personnel

Ask staff to refer families needing information and assistance to the Healthy Families/Medi-Cal for Children toll-free line at (888) 747-1222.

3. Make outreach a part of routine activities:

★ **Give parents applications or enrollment information during registration.**

4. Assist with enrollment activities:

★ **Refer families to a local community-based organization that has trained application assistants. These application assistants can help families free-of-charge in completing Healthy Families and Medi-Cal for Children applications.**

★ **Provide space/facilities within your program for local agencies and community-based organizations:**

- ♥ Hold special community enrollment events.
- ♥ Operate a "Health Coverage Information" booth during health fairs, physicals, immunization drives, and vision and hearing testing days.

★ **Encourage staff to become trained as certified application assistants (CAAs).**

Other Ideas?

We'd like to hear about your creative outreach approaches.

Contact Outreach in Action editor Cheewa James at (916) 657-1383 or by FAX at (916) 653-2781.

We'd like to share your ideas with other schools and early education programs.

CALIFORNIA SchoolHealthConnections

Need Help? Here's Where to Go!

◆ **Refer parents to the Healthy Families and Medi-Cal for Children toll-free number (operators speak 10 languages) (888) 747-1222 to:**

- ♥ Ask questions about the health coverage programs.
- ♥ Request a joint application.
- ♥ Be referred to a certified application assistant (CAA).

Programs wanting more information may also call.

◆ **Visit the Healthy Families Web Site at: www.healthyfamilies.ca.gov**

- ♥ For more information on Healthy Families
- ♥ For names of organizations that have certified application assistants

◆ **Call Richard Heath and Associates at (888) 237-6248:**

- ♥ For applications, handbooks, and display boards/tear-off pads
- ♥ To get names of agencies or community-based organizations that have certified application assistants
- ♥ To get trained as a certified application assistant (CAA) (CAAs earn up to $50 for their school or district for every family enrolled in Healthy Families and Medi-Cal for Children.)

◆ **Call School Health Connections, Department of Health Services, at (916) 653-7746:**

- ♥ To get parent information fliers (available in 11 languages)
- ♥ To get a camera-ready copy of a health care coverage summary chart that includes income eligibility guidelines (available in English and Spanish)

California Department of Health Services, 714 P Street, Room 750, Sacramento, CA 95814; (916) 653-7746; FAX (916) 653-2781

HEAD START–HIGHER EDUCATION PARTNERSHIPS

Developing University-Head Start Partnerships: A Success Story in Collaboration

by Susan Gomez, Ph.D., and Karen Horobin, Ph.D.
California State University, Sacramento

Efforts to develop and support high-quality services for young children can be greatly enhanced through the establishment of effective partnerships that foster collaboration between universities and publicly funded early education programs. This article describes the collaborative child development programs that have emerged as a result of a partnership between the child development faculty and students of California State University, Sacramento (CSUS), and teachers and staff of the Sacramento Education and Training Association (SETA) Head Start.

The CSUS Child Development program is one of the largest in the State of California and educates many of the preschool and elementary teachers employed in the Sacramento metropolitan region. One important focus of this program is to provide field experiences for students working with young children in the community. Faculty members are especially committed to ensuring that students participate in child development programs such as Head Start, which serves a rich diversity of cultural and linguistic communities in the Sacramento area.

The CSUS-SETA partnership began more than five years ago when Dr. Horobin, a CSUS child development faculty member, approached SETA about the possibility of creating a field experience in Head Start classrooms for CSUS students. Once this initial field experience was off the ground, CSUS faculty and SETA Head Start staff began to discover other avenues for collaboration. Today, CSUS and SETA have developed a multifaceted, dynamic partnership that brings together professors, university students, Head Start teachers, administrators, children, and families in a variety of programs.

Programs Operated Under the Partnership

Over the past five years, the CSUS-SETA partnership has produced several different programs that link university faculty and students with Head Start teachers, children, and families. Some of the programs involve direct interaction between students and children through classroom-based observations, tutoring, or other teaching assignments. Depending on the type of program, university students may do volunteer work or receive payment for their services. Other collaborative program elements involve staff development, training, or research projects. The programs operated under the partnership are as follows:

Tutoring Programs for Children

CSUS students serve as tutors in SETA Head Start classrooms through two federally funded work study programs: America Reads and America Counts.

America Reads. This program was designed by Congress to provide financial aid to college students in the form of work study funds to provide literacy tutoring of preschool through middle school children across the nation. CSUS faculty members Doctors Gomez and Horobin secured work study funding through the university to pay for the services of student tutors and, in partnership with SETA, developed a team of America Reads tutors, who have been working in Head Start classrooms across the metropolitan area since the fall of 1997. This is at no cost to SETA because America Reads monies are 100 percent federally funded.

Dr. Gomez conducts weekly training sessions for student interns, which focus on developmentally appropriate methods and materials for fostering literacy concepts in preschoolers. Training content and activities are also integrated with the Head Start curriculum and philosophical approach. Each student tutor is assigned to one Head Start classroom for approximately six to eight hours per week through the course of the semester. Students work collaboratively with Head Start teachers in planning activities and interacting with children in the classroom. For their tutoring services students not only get paid but also receive course credit through the CSUS Cooperative Education Office, which provides college credit for students' work experiences related to their degree.

America Counts. Last year, Congress expanded funding to include work study grants for America Counts, a new offshoot program that focuses on developing the numeracy skills of children. Dr. Horobin has secured additional federal funds to organize a new CSUS team of tutors for the America Counts program. The student tutors will be placed in SETA Head Start classrooms in the fall of 2000. Like America Reads tutors, America Counts tutors will be paid through work study funds, will participate in ongoing training conducted by Dr. Horobin, will plan and implement activities in Head Start classrooms, and will receive course credit through the Cooperative Education Office.

Substitute Teacher Program

As CSUS students worked in SETA classrooms during the last several years, Head Start teachers and staff began to recognize and appreciate the students' education, experience, and teaching abilities. On an occasional basis SETA asked students to serve as substitute teachers. As this informal process continued, discussions began during the CSUS-SETA staff meetings about formalizing the arrangement. SETA was in need of qualified, dependable, and available substitute teachers; CSUS child development students were always in need of paid work experiences with young children. In the spring of 1999, Doctors Horobin and Gomez recruited an initial team of CSUS students with some course work in child development for substitute work. After screening the students SETA Head Start hired them as substitute teachers. Like other substitutes, CSUS students have to complete all required paperwork, meet minimum requirements for child development and early childhood education, and undergo background checks. Unlike other substitutes, however, CSUS student substitutes are guaranteed a minimum of ten hours of work per week (although they may work more hours if their schedules permit). Rather than working on an on-call basis, they are assigned to a home cluster of Head Start sites within the region. When necessary, however, they do travel to other sites outside their cluster.

The substitute program has many benefits for both partners. Students gain valuable field experience in early childhood classrooms, have excellent part-time jobs, and attain course credit through the university's Cooperative Education Office. SETA Head Start is guaranteed a stable pool of qualified substitute teachers at a low cost, thus addressing the critical shortage of substitutes for Head Start programs. Last year the national review team commended SETA for its partnership with CSUS. The reviewers were especially impressed by the substitute program.

Community Service Learning Experiences

One option in the university's introductory child development course is for beginning child development students to participate in Head Start classrooms as volunteer observers. After going through background checks required by SETA, students complete 30 hours of observation during the course of a semester in one Head Start classroom. This activity fulfills one of the major assignments in the child development course. Many of these students go on to participate in the tutoring program or substitute program after their observational experience.

Collaborative partnerships require commitment, hard work, and dedication to common goals in order to succeed.

Staff Development and Training

Continual sharing of knowledge and experience between CSUS faculty and SETA teachers and staff has been critical to the operation of the programs. CSUS faculty are regularly invited as trainers to Head Start teachers' orientations and in-service workshops. And SETA Head Start staff go to university class meetings and share information about Head Start programs—their philosophy, curriculum, and practices.

Research Initiatives

University faculty have had the opportunity to plan and conduct research projects in conjunction with the tutoring programs. For example, the impact of the America Reads tutoring intervention has been studied and assessed for its effects on participating tutors, teachers, classrooms, and children. Findings indicate a statistically significant improvement in several areas of children's literacy and many positive effects on teachers and classrooms. Results of the research have been disseminated through presentations of the partnership programs at local, state, and national conferences as well as through scholarly publications in journals, such as the *National Head Start Association Dialog* (see the references after this article for more information about the research studies). Researchers continue to monitor the effects of the literacy tutoring programs and will expand their efforts next year to include an in-depth study of the numeracy tutoring intervention program.

Keys to a Successful Partnership

Collaborative partnerships require commitment, hard work, and dedication to common goals in order to succeed. A key strategy for developing and maintaining the CSUS-SETA partnership is a cyclical process of collaborative planning, communication, and problem solving through regularly scheduled meetings and almost daily informal communication. CSUS and SETA Head Start communication has been facilitated by the mutual respect and shared values that the parties have been able to sustain, even in the face of barriers and problems. As each program developed, an important step in early planning involved establishing a shared vision of common objectives, purposes, and operating parameters balanced by acknowledgment of each partner's diverging perspectives, resources, and needs. This balancing act has been facilitated by a common perspective that each partner and each participant (faculty members, Head Start staff, teachers, students, and children) contribute to the success of the programs. The partners have also been able to capitalize on their strengths, especially in terms of seeking out support and resources for maintaining and operating many program options. Both CSUS and SETA have contributed time, resources, and effort to make the programs work as well as they do. But as in any other group

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Developing University-Head Start Partnerships: A Success Story in Collaboration

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endeavor, the CSUS-SETA partnership has faced, along the way, some worrisome obstacles and problems, many of which are universal to the process of collaboration regardless of who the partners may be. However, the CSUS-SETA partnership has been able to put in place measures to overcome or minimize these problems.

The more pressing problems that the collaboration has faced are as follows:

Paperwork, or bureaucracy, bureaucracy, bureaucracy! One continual frustration for all involved in the team has been the endless amount of paperwork and processing needed to operate the programs. There are CSUS requirements and paperwork for financial aid and for the Cooperative Education and the Child Development programs. There are SETA forms for personnel, payroll, and background checks. And there are various forms and requirements for each of the different programs. Keeping up with the details and juggling so many students in so many different programs and classrooms have been a logistical nightmare at times.

Miscommunications, or he said, she said. Despite all efforts to meet and communicate regularly, details may be overlooked, important information sometimes can be misunderstood, and problems may go seemingly unnoticed. It is especially challenging to communicate effectively when so many of the participants are spread out over different entities and housed in so many different locations.

Establishing relationships among partners, or getting to know you. Building a long-term collaboration, involving so many programs and individuals, starts with forming foundational relationships. For universities and community agencies, those first steps are often colored by previous misconceptions and assumptions each partner may have about the other. In the CSUS-SETA partnership, there had not been any long-standing relationship between the university and community preschool programs, much less Head Start. Each partner's initial assumptions had to be overcome, and both partners had to work together to build a foundation for successful collaboration.

Developing shared goals and vision, or do you see what I see? Even if parties can agree that they have similar interests and purposes, the hard work of forging a shared set of concrete goals must be accomplished if the partnership is to succeed. Achieving this shared vision can be difficult in light of partners' differing needs, expectations, values, and perspectives. When there has not been a history of collaboration, efforts to form partnerships may be looked upon with skepticism.

Building a long-term collaboration, involving so many programs and individuals, starts with forming foundational relationships.

Overcoming Obstacles and Problems

The hardest work of the partnership has been and continues to be overcoming these obstacles and problems. Yet engaging in this work has been critical to the success of the CSUS-SETA collaboration. Representatives of both CSUS and SETA have been able to establish an atmosphere of honest discussion and recognition of the problem areas, and they have worked together to address the problems by developing and implementing the following strategies:

Ongoing communication. Perhaps the most important strategy has been maintaining ongoing communication that involves all constituents in planning and problem solving. Formal planning and information meetings are held to discuss the status of current programs, to brainstorm, to develop new programs, and to address problems as they arise. In addition, many hours of telephone consultation and e-mail exchanges have taken place. Because the partnership has to deal with so many different individuals with varying responsibilities, it has designated key CSUS and SETA contact persons to participate in all planning and to serve as liaisons to other persons within their organization when necessary. It has also developed a core team of SETA staff who work with CSUS faculty and students on paperwork and processing issues.

Bringing up such sensitive issues as undue absence of students in field placements or approaches to child guidance used in the classrooms can be uncomfortable for all parties. However, ignoring the problem areas may serve only to compound them. Openly addressing those issues in an effective, constructive, and collaborative dialogue can be a learning opportunity for all and bring about solutions that strengthen the partnership.

Ongoing evaluation of each program's progress. The continuous evaluation of each program's progress has helped the partnership to monitor its effectiveness, identify problem areas, and create solutions. This circular process of evaluation has been helpful in gathering information from many different participants—teachers, faculty, staff, and students. This information is most useful when elicited in a fashion that encourages honest and direct sharing of problem areas. Once areas of need are identified, CSUS and SETA personnel work together to develop and implement solutions that are both realistic and effective.

Working Partnerships

Partnerships such as those that have been described, which link key stakeholders in early childhood education, provide effective and cost-efficient ways of improving the quality of programs and services offered to young children and their families. University students, in the process of providing extra help and individual attention to children in busy Head Start classrooms, gain valuable experience working with young children under the dual guid-

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Head Start–Child Care Partnerships

Boost4Kids

by Christina Linville, Deputy County Administrator, Contra Costa County

Boost4Kids (B4K) is a national initiative to improve service outcomes for children and families by promoting stronger partnerships among federal, state, and local governments and by highlighting innovative efforts at the local level. In May 1999 Contra Costa County was selected to join two other counties—Placer and San Diego— to form the California B4K Caucus with their federal and state partners, becoming one of ten sites in the nation to be designated as a B4K Performance Partnership. At the federal level B4K is sponsored by the National Partnership for Reinventing Government and is supported by several federal agencies, including the U.S. Department of Health and Human Services and the National Highway Traffic Safety Administration. The state-level partner of the California B4K Caucus is the California Health and Human Services (HHS) Agency. Each county partner also has a local sponsor—the Contra Costa Children and Families Policy Forum in Contra Costa, the County Department of Health and Human Services in Placer, and the County Health and Human Services Agency in San Diego.

By improving service outcomes for children, performance partners reap benefits from their B4K status in the following ways:

- Greater flexibility in administering grant funds (as current law allows) in programs with related goals
- Opportunity to consolidate planning and reporting for some programs and to test innovations that are designed to reduce administrative constraints (those that restrict the way existing funds are used and those that negatively impact clients and staff, who must complete extensive and often duplicative paperwork to meet time-consuming and labor-intensive reporting requirements), resulting in administrative savings
- Ability to pool the administrative savings from discretionary grant programs (as current law allows) and fund direct services in local programs for children and families
- Increased access to federal data and geographic information and help from federal data experts in devising strategies for collecting and analyzing data on child-related outcomes
- More comprehensive, effective, and substantive working relationships with federal and state sponsors and expanded collaborations with local partners through the sharing of best practices and lessons learned

Each county in the California B4K Caucus is using its B4K status to work on at least one major project, identified at a joint federal, state, and county meeting in August 1999, as follows:

Contra Costa is leading the effort to develop mechanisms to blend (or "braid") funding and to develop services based on reliable data. All three counties will continue to collaborate with the state to integrate services.

Placer is working to streamline and centralize the application process and information systems for a variety of programs.

San Diego is leading the effort to explore "express lane eligibility" strategies that are intended, through reduction of paperwork, to increase children's access to health insurance and to programs with equivalent income eligibility requirements, such as Food Stamps; Women, Infant, and Children; and National School Lunch Program.

Contra Costa's Boost4Kids activities, like those of the other county partners, are designed to support services integration with the Youth Pilot Program and build on the program's other activities and strong state-local collaborative work and technical assistance that have been part of its program for the past several years. The Youth Pilot Program was created by Assembly Bill (AB) 1741 to give six counties—Alameda, Contra Costa, Fresno, Marin, Placer, and San Diego—the ability to blend funds, test alternative approaches, and develop comprehensive, integrated service systems for children and youth. All six counties participating in the Youth Pilot Program are considered beneficiaries of and contributors to the California B4K efforts.

Boost4Kids Activities in Contra Costa County

Contra Costa's major Boost4Kids-related activities are (a) implementing Contra Costa Futures; (b) promoting Direct Certification; and (c) supporting the Youth Pilot Program's Contra Costa Service Integration Program.

A. Contra Costa Futures

Contra Costa (CC) Futures is more than a model or program; it is a new service environment. The elements of CC Futures give structural support for new ways of providing human services. These elements include:

- A linked, aggregated, anonymous database for planning and research

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Fostering Infant/Family Mental Health

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recognize whether the baby has a regulatory disorder affecting sleep or appetite, for example, and to work with the mother to soothe the baby and to help the baby find a more regular pattern of sleep or hunger.

Effective intervention requires a certain level of knowledge and skill, but it does not need to occur in a particular setting. It may occur in a hospital ward, clinic, day care setting, or family kitchen. What makes intervention effective is the training of the interventionist and the quality of the relationship that the interventionist establishes with the mother and baby. The interventionist works with parents to make daily routines enjoyable rather than burdensome and uses techniques for helping parents increase their awareness of their relationship with their child. The focus is on the relationship between the infant and parent—not on the infant alone or the parent alone.

What qualifies an infant interventionist?

An infant interventionist possesses three general sets of competencies:

1. Knowledge of infant and early childhood motor, language, and emotional development
2. Understanding of types of attachment and the difficulties some adults may have in forming an attachment with a child
3. Intervention skills that foster the growth of the caregiver as a capable parent

The training and experience to be an infant interventionist may be derived from such fields as medicine, nursing, psychology, social work, or early childhood education.

An infant intervention program is only as effective as the interventionist. Because of the tactical, transportation, and access problems that low-income families usually face, parent/infant intervention programs typically are situated in neighborhood clinics or community centers and often include outreach services, such as home visiting. Treatment effectiveness is not contingent on the intervention occurring in the home but on the interventionist's skill and training. The work of Dr. David Olds, director of the Kempe Prevention Research Center for Family and Child Health, has also shown that:

1. Later outcomes for high-risk families who have had home visiting intervention demonstrate less symptomatology and a reduced rate of juvenile justice system involvement.
2. The greatest effect of intervention is found to be for the families who need it most.
3. The use of inadequately trained home visitors is less effective than the use of well-trained and experienced home visitors because of attrition, turnover, and so forth (finding of a recent Denver study).

Does infant intervention work?

Effective early intervention programs have been shown to save tax dollars in educational costs (the need for special educational services is reduced), welfare assistance, and criminal justice system expenses. For example, in a model outreach intervention program entailing monthly one-hour visits to low-income families in rural Appalachia, adolescent mothers had an enhanced quality of parent–child interaction, more appropriate developmental expectations for their children, and improved obstetric and neonatal outcomes.

In another program—a randomized trial of intensive treatment compared with the usual available services—97 children who received 25 visits lasting 1/5 hour each during their first year of life were compared with 119 control-group children. A follow-up done when the children reached grades two through five showed that the children who received early intervention had higher developmental, cognitive, and verbal communications skills and fewer destructive, overactive, and negative attention-seeking behaviors than did the children in the control group.

Longitudinal studies yield a consistent finding that the effects of early intervention are cumulative. The longer the period after intervention that the outcome is measured, the more positive are the effects. Because the child is developing and because standardized measures are useful in limited age ranges, it may be necessary to use a different measure at a later time than the one used as the baseline. Standardized measures are available for all age ranges, allowing the objective assessment of program outcomes.

As for research on policy and program issues, the implications are obvious—the dollars spent for early intervention will save a greater expense later in the form of costly interventions for the older child. For example, home-based mother–infant intervention is less costly than special schools, out-of-home placement, and so forth. For children and mothers who received monthly visits by nursing staff, a follow-up conducted when the children reached fifteen years of age showed a lower rate of child abuse and neglect as well as a lower rate of drug or alcohol use by the mothers during subsequent pregnancies.

The hope is that implementation of the IFMHI program will reduce children's and families' suffering as well as increase the constructive experiences of developing children and enable them to become fully functional adults.

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Problem-Solving Steps as a Tool for Reflective Thinking About Children with Challenging Behavior

(Continued from page 11)

3. **Partner with the parents.**

   Verify the data you have gathered.

   Involve parents as you embark on the next steps.

   Remember, this topic is likely to be sensitive for the family and will probably trigger their emotions and reactions. Knowing that ahead of time may help you *act* rather than *react* and help in the overall management of the emotions. You may even be able to offer support to family members.

4. **Generate as many solutions as possible.**

   Brainstorm ideas.

   If doing this with a group, list all ideas without criticism or praise.

5. **Choose one possible solution and make a plan.**

   From the list, select the plan you believe will be most effective.

   Determine how to implement the plan.

6. **Implement the solution chosen.**

   Stick with your implementation plan.

   Determine the point at which you will evaluate the solution.

   Choose only one solution at a time.

7. **Evaluate the solution.**

   Remember, you are aiming for improvement, *not* perfection.

   If it works, you will know—your energy will no longer be focused on the situation.

   If the solution did not work, recheck to see whether you defined the problem correctly.

   If the problem was defined correctly, choose another possible solution.

   Do not be afraid of "failing." It is a proven way to learn.

   Realize that with solutions come new questions and new understandings.

Responsive Teaching: Nurturing and Supporting Children's Social and Emotional Development

(Continued from page 17)

asked to identify teachers who are responsive, the first attribute often listed is "the way they talk to the children." Responsive language is a very important skill, as Susan Kontos found in her 1997 study. She states, "The quality of the talk is likely to be related to the quality of the program." Janet Stone also emphasizes the importance of a teacher's language in her 1993 article in *Young Children*. She explains how language is on a continuum from restrictive, such as threats and punishments, to responsive, which conveys positive regard, conveys respect for and acceptance of individual ideas and feelings, encourages verbal give and take, encourages independent thought, implies alternatives and choices, provides extra information, and uses nurturing vocabulary.

Nonverbal communication is the physical display of mood—facial expressions, gestures, attentiveness, body posture, body position, and energy level—or what is commonly known as *body language*. Responsive nonverbal communication is an equally important element of responsive teaching, and it has a remarkable effect on the quality of communication. For example, simply increasing the teacher's attentiveness to the children almost magically increases the children's enthusiasm and interest.

Responsive teachers communicate acceptance, love, and warmth by being fully present and engaging with the child as they interact; listening attentively; giving physical cues of encouragement and support through smiles, nods, and pats; and matching their own energy and activity level to the child's needs.

- *Joyful interactions.* Responsive teachers take joy in their work. They are appropriately playful, and laughter is frequently heard in their classrooms.
- *Problem solving ability.* Responsive teachers facilitate solving the children's problems before conflict happens. When necessary, they intervene in a nonjudgmental manner that supports all children involved.

- *Knack for giving appropriate and authentic praise.* Authentic praise is predominant in responsive classrooms. Instead of doling out empty praises by using evaluative terms such as "Good boy," responsive teachers praise children by making statements such as "You tied your shoes all by yourself. That makes you feel proud!" Praise helps children identify and gain satisfaction from the intrinsic rewards they receive from their accomplishments rather than from the extrinsic rewards.
- *Understanding of the importance of emotions.* While teachers usually understand the importance of emotions and provide opportunities for children to explore, talk about, and express their feelings, responsive teachers go a step further and provide sensitive role models by expressing and labeling their own feelings. For example, "I'm feeling frustrated because I can't find my pen. Can you help me look for it?"
- *Positive relationships with others.* Responsive teachers develop positive relationships not only with the children but also with their parents and other members of the teaching team. The responsive teachers see their role as working *together* with parents to support children's development and well-being, not just as agents assigned simply to inform parents of their children's progress. They are nonjudgmental and seek to understand each parent's perspective, especially when it is different from their own. Just as important are relationships with the other adults in the classroom. Responsive teaching teams treat each other with mutual respect and high regard. They communicate openly, honestly, and continuously. Their work with children and families becomes a parallel process to their relationships with each other.
- *Ability to develop nurturing and supportive environments.* Responsive teachers understand that classrooms can easily become overstimulating for children, and they work to keep them simple and orderly yet warm. They give children a sense of belonging by reflecting the culture and ethnicity of the enrolled families in the furnishings and materials. They plan and develop environments that are comfortable, safe havens for children, including private spaces and soft, cozy corners where children can self-soothe, as well as places where the children can appropriately release pent-up energy.

How do teachers become responsive? Responsive teachers attribute many of their responsive behaviors to nurturing relationships with their own

parents, caregivers, or both. They also report learning caring behaviors from supervisors, colleagues, their own childhood teachers, mentors, and college instructors. Some responsive teachers credit theorists (e.g., Maria Montesorri and Urie Bronfrenbrenner) for influencing their style. Responsive teachers are also self-reflective. They have developed a high level of self-awareness by reflecting continually on the quality of their daily interactions, professional skills, and knowledge.

How do responsive teachers continue to perfect their skills? Responsive teachers continuously perfect their skills through reflection, a core behavior common to them. Some reflect through formal processes, such as completing professional portfolios; videotaping themselves; debriefing with their team teacher; or meeting regularly with a supervisor, a mentor, or both (reflective supervision models). Others keep a journal, make informal notes for planning, or reflect on their own work by simply thinking about it. As simple as it may seem, the practice of reflection makes a significant, positive difference in a teacher's performance. Responsive teachers keep on improving themselves and increasing their skills and knowledge through professional development. They see themselves as lifelong learners.

Their social competence is nurtured, and they learn to express feelings appropriately by modeling their teachers.

Benefits and Results of Responsive Teaching

When one walks into the classroom of a responsive teacher, the positive energy is immediately apparent. Children feel safe and secure, exhibit less stress, and accept guidance. They are able to put their energy into their work and play. They learn to respect materials and each other. Their social competence is nurtured, and they learn to express feelings appropriately by modeling their teachers.

As the number of young children participating in early care and education programs continues to increase, it is more important than ever that we recognize the significant role teachers play in nurturing and supporting children's social and emotional well-being. When children are in the care of responsive teachers, they know they are cherished and valued. In turn, they learn to love themselves and trust others. As Lilian G. Katz and Diane E. McClellan remind us, "teachers who work with young children can have a profound impact on children's social development—an impact that can contribute to the quality of children's lives throughout their life span."

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Child Care Mental Health Consultation: A Relationship-Based Model

(Continued from page 13)

change empowers those who have strong daily interactions with children and their families and enables them to be the lead agents of change. Although the specialized training needed by child care providers to work effectively with children who have special behavioral needs is not required or readily available (early childhood education and training focus principally on typical child development, education, and curricula), progress is being made to further develop and make specialized training available through the efforts of such projects as the Map to Inclusive Child Care Project and the Community College Pilot Project. The model for specialized training offers ongoing support and the opportunity for reflective supervision to an overworked, underpaid workforce caring for California's children.

Mental health consultants view child care providers as clients. This model attempts to address and target some of the known needs of child care providers through support, guidance, modeling, and training, highlighting the importance of a parallel process. Child care providers and mental health providers bring different backgrounds and orientations toward understanding children's behavior. If consultation is to be truly effective, it is important to value each professional's point of view in order to facilitate the development of collaborative partnerships among all the important adults in children's lives.

Consultation in child care programs is not a new concept. However, any attempt to institutionalize these services on a systemic level is a venture into new territory and poses challenges. The Child Care Mental Health Project is attempting to address some of these issues by challenging the current systems to accommodate within the existing fiscal infrastructures what it believes to be the best approach to consultation—a relationship-based model of child care consultation. Building relationships among and between all the significant adults in a child's life serves as prevention, intervention, and treatment, all of which promote the most enduring and optimal outcomes for young children, their families, and the providers who care for them.

For more information regarding the Child Care Mental Health Project, contact Jennifer Smith of the Child Care Health Program at (510) 839-1195.

Infant/Family Mental Health and Relationship-Based Approaches: An Emerging Field

by Sheila Wolfe

The increasingly recognized field of infant/family mental health and its practice areas hold great significance for parents, families, communities, and the wide-ranging service providers who work with very young children and their families in many different settings. Some of the terms used in this emerging field are defined as follows:

Infant/family mental health. This term encompasses (1) a focus on very early relationships and interactions between infants and their parents and others who may serve as the child's "family"; (2) the emotional and social well-being of babies and their families; (3) the "goodness-of-fit" between infants and their families; and (4) an acknowledgement of the significant impact that a child's emotional-social well-being in the very early years has on the child's learning and overall development throughout life.

Relationship-based approaches. This term refers to the emotional supports and strategies that can be used to understand, nurture, develop, promote, and sustain positive interactions and mentally healthy relationships between (1) children and their parents and families; and (2) children and others who care for them.

Infant/family mental health promotion. This term refers to the promotion of and ongoing support to nurture positive infant–parent relationships as a core component of all work with young children and their families.

Infant/family mental health preventive intervention. This term refers to a more focused and individualized support and intervention for infants and families when relationships are challenged or are at risk of difficulties because of a child's health or developmental problems, family stress, unexpected crisis, or any other difficulty that may hinder positive interactions and relationship building between the child, the family, and other primary caregivers.

Infant/family mental health treatment. This term refers to more intensive intervention and mental health treatment services for young children and their families when significant disturbances and problems in the infant–parent relationship place the child at high risk of emotional-social problems and mental health difficulties and interfere with the parent's or family's ability to nurture and care for the child.

There are many opportunities for fostering a child's emotional and social well-being and promoting positive interactions and a "goodness of fit" between young children, their parents, and their other significant caregivers.

There are many opportunities for fostering a child's emotional and social well-being and promoting positive interactions and a "goodness of fit" between young children, their parents, and their other significant caregivers. Here are a few ideas that child development and child care professionals might consider using:

1. Talk with individual families, provide written information in your program descriptions, and include videos and discussions during parents meetings or get-togethers to convey the importance of positive interactions and the parent's early relationship with their child. *Include tangible examples and descriptions of how those positive relationships are fostered; for example, "Matt really smiles when you lean over and hug him."*
2. Let each family know that you believe in their ability to nurture and care for their child and that you too will be working to nurture and support that relationship. *Include tangible examples and descriptions of how you will provide that support; for example, "We'd like to take a picture of you and Susan together so she can look at it throughout the day and we can talk about all the things you like to do together."*
3. Look for opportunities to call attention to the positive things parents say and do with their child. Comment on how those positive things affect their child during the specific interaction and throughout the day. *Include tangible examples and descriptions of what they each said or did and how those things affect the other; for example, "Did you notice how quickly Frankie stopped crying when you looked at his hurt knee and kissed it? Knowing you cared, he really seemed to relax."*
4. Try to notice what actually happens during positive parent–child interactions and other positive child–caregiver interactions so that you and the parents can identify what works and what kinds of interactions or exchanges have a positive impact—and why; *for example, "I notice that when you hold Mary's hand for a moment before you leave, she seems to let me help her to say her good-byes to you. I can see that you know how important you are to her."*
5. When possible, talk with parents, provide written information and materials, and include extended family members in activities so that everyone in the "family" can see that they can have a positive impact on the child's emotional and social well-being and development; *for example, "I noticed that Jake laughs and touches all the pictures in the book about grandmothers, and I*

remembered your mentioning that your mother often cares for him. Would you like to borrow the book for her and Jake to share at home?"

6. Focus on understanding parents and families and finding positive aspects of the child–parent relationship. Identify what is going well between them and how the relationship can be supported, nurtured, and developed—especially during times of stress; *for example, "I notice that Jenny often cries as you sign out, and I wonder if it might be easier if you were to greet her with a 'hello' before signing out. She seems to be trying to reach you as soon as she sees you come in—what do you think? Is there anything I can do to help?"*
7. Share ideas, information, and approaches with your colleagues and team that describe experiences, events, and actual interactions that took place and seemed to nurture positive interactions and relationships; *for example, "I could see that Manuel found a toy that interested him when you picked it up and held it near your face," or "He really giggled when you sang his name so quietly—it looked like the two of you were having fun!"*
8. Focus on experiences and interactions that encourage exploration, discovery, and learning for both the child and the parent—together and individually. Consider both child and adult learning approaches and what you can do to facilitate the process; *for example, "I'd like to spend a few minutes with you and Lynn today playing with the cups and lids. She usually makes a lot of sounds and puts them together in new ways. And she is really starting to imitate others as she plays."*
9. Support children and families in coping with difficult adjustments to changes in their lives and in their relationship. Identify the strategies that may have already worked for them in previous situations and look for ways to use those approaches to address problems at hand; *for example, "I was sorry to hear about your move. How are you and Jamel coping with the change? I'll stay near him a bit more today—that seemed to help when he first started here. What seems to help at home between the two of you?"*
10. Consider yourself part of a team; fostering positive interactions is important and sometimes difficult work, and teamwork makes it easier. Find ways to nurture yourself and to obtain the support, supervision, consultation, and training you may need. *Contact your local and professional support organizations to learn more about infant/family mental health and resources on relationship-based approaches.*

This article was adapted by Sheila Wolfe from several infant/family mental health resources. Ms. Wolfe is the project coordinator for the Infant/Family Mental Health Initiative, a special project funded by the California Department of Mental Health and coordinated by the WestEd/CEITAN Center for Prevention and Early Intervention in collaboration with the Alameda, Fresno, Los Angeles, and Sacramento county departments of mental health. For more information about this project and related resources, call (916) 492-9999.

Developing University-Head Start Partnerships: A Success Story in Collaboration

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ance of seasoned teachers and teacher educators. Head Start classrooms get additional staffing, an especially critical need as the number of parent volunteers has decreased with the implementation of welfare reform. And with child development students in their classrooms, Head Start teachers are encouraged to reflect on their teaching approaches and practices and are often motivated to continue their own professional growth and training. University faculty gain greater understanding of life in the Head Start classroom through on-site observations, which help them in their teaching preparation and in training child development students. Furthermore, this type of field-based career experience for university students during their college years has proved to be an excellent recruiting strategy; several CSUS students have gone on to full employment with SETA Head Start after graduation.

Opportunities for collaborative research have brought together theory and practice; teachers and teacher educators; evaluation of curriculum, materials, and methods; and curricular changes that are particularly valuable in the areas of literacy and numeracy in light of new Head Start program performance standards.

Sustaining a collaboration, such as the CSUS-SETA partnership, over a long period of time—across different programs, through changes in university and Head Start staff, and through repetitive cycles of new students, children, and families each school year—is a testament to the value of the partnership for CSUS faculty and students, for SETA staff and Head Start teachers, and, especially, for the children that the partnership strives to serve.

For more information about the programs described, please contact Dr. Gomez (e-mail: gomezs@csus.educ) or Dr. Horobin (e-mail: kdhorobin@csus.educ) at California State University, Sacramento, Department of Teacher Education, Sacramento, CA 95819-6079.

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Boost4Kids

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(so far, a prototype of the Children and Family Archive database has already been developed)
- An interagency fiscal infrastructure that braids categorical funds to maximize revenues
- A fund pool for comprehensive children and family services and reinvestment in prevention and early intervention services
- Software that tracks services, allocates these services to funding sources, and provides information to evaluate the effectiveness of intervention services

A local Interagency Fiscal Work Group, made up of fiscal officers from Employment and Human Services, Health Services, Contra Costa County Office of Education, the Mt. Diablo Unified School District, Community Services, and Probation Department, is readying recommendations for braided funding, fund pool criteria, and initial applications of the CC Futures model.

B. Direct Certification

Direct Certification is a system that eliminates the processing of paper applications by electronically matching information from schools and human services agencies to directly certify eligible students for free or reduced-price school meal programs. Staff in the county administrator's office are currently working with staff from the county office of education, local school districts, California Food Policy Advocates, and the University of California Cooperative Extension on a Direct Certification initiative.

More than 42,350 Contra Costa students qualified for free or reduced-price school meal programs in 1999. To improve access to these programs, five of Contra Costa's school districts (the four largest and the county office of education) use Direct Certification for schoo! meal programs, capturing the majority of the county's eligible students. Through the current initiative, eight additional school districts are scheduled to implement Direct Certification in fall 2000, which is expected to bring the percentage of students directly certified to above 90 percent. This project is being coordinated with local Medi-Cal/ Healthy Families outreach programs to ensure that the efforts to reach families are complementary.

Direct Certification is a system that eliminates the processing of paper applications by electronically matching information from schools and human services agencies to directly certify eligible students for free or reduced-price school meal programs.

C. Service Integration of RISE Food Stamp Waiver and the Contra Costa Futures Pilot

Contra Costa's goal for the Youth Pilot Program, which is shared by the other Boost4Kids sites in California, is to expand and enhance AB 1741-related services through the technical assistance afforded by Boost4Kids. To this end Contra Costa has requested technical assistance in implementing the federal RISE (Re-Investing in Self-Sufficiency Through Employment) Food Stamp waiver. RISE reduces paperwork associated with income reports through the use of the CC Futures database so that the time saved can be reinvested in employment-related contacts with, and services to, families. The first RISE data are expected in fall 2000.

Other Key Benefits of Participation in Boost4Kids

New working relationships. From the local perspective the development of new structures for working with state and federal partners has been the most significant benefit of technical assistance. The California Caucus meetings, conference calls, and e-mail linkages that have been set up through Boost4Kids represent new mechanisms in which to plan and deliver services to children and families. The direct and dynamic relationship with the California HHS Agency, as well as with HHS Region IX staff, has been productive and instructive for local staff.

Technical assistance. Federal and state staff have worked with Contra Costa County on specific issues related to child care and development and on the confidentiality of cross-agency sharing of information. Contra Costa staff have consulted with the federal and state staff on local projects, such as:

- Child Start. This is a full-day, full-year child care and development effort of the Community Services Head Start and State Preschool divisions.
- Contra Costa's County Opportunities and Obligations Program (CO-OP). The CO-OP provides job placement, training, education, and parenting resources for noncustodial parents of children receiving benefits from the Temporary Assistance to Needy Families program.

National Partnership for Reinventing Government Technical Assistance (NPR). NPR, through the Boost4Kids Performance Partnership, has given Contra Costa significant technical assistance benefits, such as the following:

- Regular e-mail distributions about funding opportunities, best practices, and resources

- Biweekly conference calls, which include experts on children and family issues, national and local
- Inclusion in nationwide seminars on geographic mapping (e.g., Geographic Information System seminars), data development, evaluation, and the recent School Readiness Conference sponsored by the National Governors' Association; the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; and the Finance Project, a national-level nonprofit organization
- Access to the Boost4Kids resources Web site

Contra Costa County has used its designation as a Boost4Kids Performance Partner to further its overall strategy of services that are comprehensive, coordinated, and based on results and accountability for children and families.

Local linkages. To ensure that local agencies get timely information about relevant publications, grant applications, and upcoming conference calls in their areas of interest through a wide distritubion of B4K resources, Contra Costa has developed the following two e-mail lists for distribution to county departments, agencies, and community partners:

1. Children and Families Policy Forum Executive Committee, comprised of the leaders of the children and family service sectors—health, human services, juvenile probation, schools, colleges, law enforcement, juvenile courts, child care and development, and housing
2. Educators and service providers who are involved in after-school and youth services programs

Boost4Kids—A BOOST for Contra Costa and California

Contra Costa County has used its designation as a Boost4Kids Performance Partner to further its overall strategy of services that are comprehensive, coordinated, and based on results and accountability for children and families. Since 1994 Contra Costa has published a *Children and Family Services Budget* to allow the Board of Supervisors, county departments, and the public to better understand the ways in which expenditures affect the county's children and families. In 1997 Contra Costa began publishing the *Children's Report Card* to assist agencies, organizations, and communities in their efforts to turn the "curve" on indicators of health, economic strength and well-being, and quality of life in the county. (Look for the *1998 Children's Report Card* at Web site: www.cccoe.k12.ca.us. A *Year 2000 Supplement* to the 1998 edition will also be available at this site soon.)

The technical assistance and strengthened federal, state, and local working relationships afforded by Boost4Kids have enhanced local efforts to implement policies, services, and mechanisms that have improved outcomes not only for children, families, and communities in Contra Costa but also for all those throughout California. Through Boost4Kids Contra Costa and the other county sites have become more effective partners in the regional and statewide efforts for systemic change to benefit children and families.

To learn more about Boost4Kids, visit the B4K Web site: www.boost4kids.gov.

Focus on the Region IX Head Start Regional Coordinating Council

by Mary Ann Walker, M.A., Senior Project Specialist, Region IX QIC-DS, California Institute on Human Services, Sonoma State University

Region IX RCC Mission: "Plan, support, and coordinate innovative, high-quality training and technical assistance to early childhood and family support programs for continuous improvement of services through collaborative, cost-effective approaches."

In 1996 the federal Head Start Bureau conducted an evaluation of the national Head Start Training and Technical Assistance (T/TA) System as part of the bureau's effort to improve Head Start services. Information and recommendations were collected from a variety of sources, including focus groups throughout the country. Focus group participants included Head Start grantee staff and administrators, parents, Administration for Children and Families (ACF) regional office staff, and T/TA providers.

Analysis of the data—qualitative as well as quantitative—gathered from the evaluation led to the revamping and revision of the Head Start T/TA System. During the revision the Head Start Bureau worked toward establishing a highly effective T/TA service delivery system that would support and facilitate the national continuous improvement initiative regarding services for Head Start/Early Head Start enrollees and their families. The revised system incorporated a four-phase cycle as the framework for planning and delivering high-quality T/TA services. The cycle consisted of the following phases:

1. Assessment of T/TA needs
2. Planning and coordination in the delivery of T/TA services
3. Implementation of a T/TA plan
4. Evaluation: What worked, and why? What did not work, and why?

Because a top recommendation made by the focus groups was to reduce fragmentation in the delivery of T/TA services, the Head Start Bureau placed an emphasis on collaboration and partnership in the planning and delivery of those services. To achieve that shift in emphasis, the Head Start Bureau established T/TA regional coordinating councils (RCCs) to play an integral role in phase 2. From a national perspective, RCCs were to serve the following broad purposes:

- Reduce fragmentation of the T/TA system by pooling resources, providing clear descriptions of each provider's services, and establishing a regional master training calendar.
- Promote the sharing of information.

Each region was charged with creating an RCC, developing a mission statement, and engaging in a strategic planning process to clarify the roles and responsibilities of its RCC.

- Foster collaboration between Head Start and its partners (for example, community colleges, Institutes of Higher Education [IHEs], and other T/TA projects, such as Map to Inclusive Child Care) in the larger community.
- Provide advice to the Head Start Quality Improvement Center (HSQIC, Development Associates, Inc.), the Quality Improvement Center for Disabilities Services (QIC-DS, CIHS, Sonoma State University), and other Head Start/Early Head Start T/TA providers.

Each region was charged with creating an RCC, developing a mission statement, and engaging in a strategic planning process to clarify the roles and responsibilities of its RCC. In their Requests for Proposal for the cooperative agreement T/TA grant, the QICs described strategies, work plan goals, and objectives that would support the mission of their respective RCC.

The concept of an RCC was not new to Region IX. Under the leadership of Maria Fort, Program Specialist with the Region IX ACF and Region IX ACF/HSQIC liaison, and in partnership with Development Associates, Inc., and CIHS, Sonoma State University, Region IX already had in place its Region IX T/TA Network. Regularly scheduled meetings provided a forum in which to discuss T/TA services and emerging issues, share information, and network with Head Start/Early Head Start T/TA providers. In recognition of this pioneering effort to coordinate services at the regional level, the Head Start T/TA Branch requested that Maria Fort give a presentation on the Region IX T/TA network at a national T/TA network meeting.

In creating its RCC, Region IX has used a strategic planning process to develop goals and objectives to support its mission statement. One of the goals is to develop guidance on best practices in providing high-quality T/TA services. An example of Region IX RCC activities is advising Region IX's HSQIC and QIC-DS on their proposed T/TA approaches that support national as well as regional initiatives. Other activities include discussing the challenges to and strategies for forming successful Head Start-Child Care partnerships and maintaining an ongoing T/TA needs assessment process.

At the April 2000 RCC meeting, Region IX's CIHS presented an overview of California's Desired Results Project. That project addresses the need

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Focus on the Region IX Head Start Regional Coordinating Council

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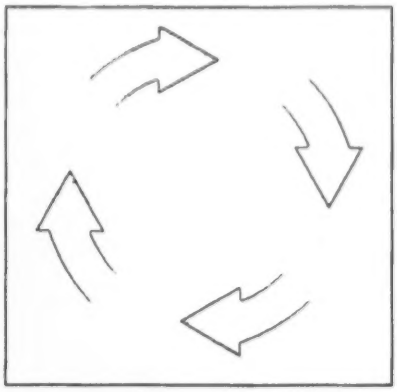
for measurable outcomes for children enrolled in state-funded child development programs. While the project will benefit young children with disabilities by developing appropriate outcomes, accommodations, and adaptations for them, it will also help minimize duplicative work in developing measurable child outcomes by Head Start.

Region IX RCC membership consists of representatives from the following agencies and projects:

- Region IX ACF, Head Start
- Region IX ACF, Child Care Bureau
- Region IX HSQIC, Development Associates, Inc.
- Region IX QIC-DS, CIHS, Sonoma State University
- Region IX State Head Start Collaboration Projects
- Region IX State Head Start Associations
- Region IX Head Start Association



- Hilton Early Head Start National Training Program
- Early Head Start National Resource Center
- Regions XI and XII (Indian and Migrant) HSQIC and QIC-DS
- Child Care Law Center
- Super Head Start Grantee (Los Angeles County Office of Education)

The Region IX RCC meetings provide a forum in which members can discuss national updates and share information on T/TA opportunities. Members also present T/TA activity updates from their respective projects, organizations, and programs. Ms. Fort and Bob Beggs, who is also a Program Specialist and Region IX ACF/QIC-DS liaison, cohost the quarterly meetings, which are held at the Region IX ACF Regional Office in San Francisco. HSQIC, in partnership with Region IX ACF and Region IX QIC-DS, develops the agenda. Region IX QIC-DS records and disseminates meeting minutes. The minutes and accompanying handouts are sent to the National Head Start T/TA Resource Center (Pal-Tech, Inc.) as well as to RCC members. Maria Fort is the contact person for the Region IX RCC and can be reached at (415) 437-8445; e-mail: mfort@acf.dhhs.gov.

The Right Call for Poison Help—Any Time, Any Place in California

Do the parents in your program know where to call for emergency information on exposure to poison? Do they know that help is available in more than 100 languages? And do they know that poison information specialists are available 24 hours every day?

"The Right Call for Poison Help" project is under way to alert parents to the California Poison Control System's toll-free help line, **1-800-876-4766.** The project has developed an education kit for parents of preschool children, who account for more than 50 percent of the nearly 900 calls received daily by Poison Control. The kit, priced at $25, contains a video, instructional materials, prevention tips, telephone stickers, and an informative handout for parents. The materials are presented in English and in Spanish.

"The Right Call for Poison Help" project is under way to alert parents to the California Poison Control System's toll-free help line, ***1-800-876-4766.***

"The Right Call for Poison Help" was made possible through a $30,000 grant from the California Kids' Plates Program as well as generous donations from Kaiser Permanente and The Clorox Company. Poison Control will donate 1,300 kits to WIC, Head Start, State Preschool, California Department of Social Services, Community Care Licensing Division, and California Child Care Resource and Referral Network programs. Others may order the kit directly from:

The California Poison Control System
University of California, San Francisco
P.O. Box 1262
San Francisco, CA 94143-1262

For more information about the project, contact Linda Pope, Health Education Coordinator; telephone (559) 622-2304.

Web Resources

Associations

The **California Head Start Association** has a new Web site that features general information about Head Start, state and national policy alerts, contact information on Board and Cluster representatives, and links to related Web sites: <www.ca-headstart.org>.

The Web site of the **California Child Care Resource and Referral Network** contains a listing of local R&Rs across the state, county-by-county child care supply maps, and information on legislation and policy activities affecting the early childhood education community: <www.rrnetwork.org>.

Homelessness

The **National Center for Homeless Education** Web site provides information and links to help educators, service providers, and families ensure that homeless children have access to educational opportunities and other necessary resources: <www.serve.org/nche/>.

The **National Law Center on Homelessness and Poverty** Web site contains reports and articles, including a report on the barriers to preschool education for homeless children and a fact sheet listing the educational rights of homeless children: <www.NLCHP.org/educat.htm>.

Education

The **Early Head Start (EHS) National Resource Center** provides training and technical assistance to EHS programs. This Web site features a section on community partnerships and community building and provides access to online reports and documents: <www.ehsnrc.org>.

The **Washington Research Institute** offers parent education programs on early language development. Each program, available in English and in Spanish, includes a video and supplementary materials. The programs may be purchased at cost or borrowed for copying: <www.wri-edu.org/bookplay/>.

The Program for Infant/Toddler Caregivers represents a partnership between the California Department of Education and WestEd to create high-quality training materials, trainer institutes, and a regional support system for infant/toddler caregivers, program directors, and trainers. The Web site has information on products, institutes, model programs, and how to apply for stipends: <www.pitc.org>.

The **HeadsUp! Network's** mission is to provide a national training opportunity for Head Start staff, parents, and the broader child care community. The network provides 12 hours of training per month via satellite/television: <www.heads-up.org>.

Mental Health

The **Research and Training Center on Family Support and Children's Mental Health** at Portland State University shares information about child and family mental health services and policy issues: <http://www.rtc.pdx.edu>.

Full-Day, Full-Year Partnerships

The **Quality in Linking Together (QUILT)** project supports partnerships involving such early education programs as state-funded child care and Head Start. *Collaborative Partnerships: California's Experience with the 1997 Head Start Expansion Grants*, produced by the California Head Start–State Collaboration Office, is available for viewing or downloading: <www.QUILT.org>.

Literacy

The **Family Literacy Foundation** offers various resources for staff and families, including a recommended reading list and information on programs it sponsors, such as Youth Reading Role Models, which matches youth volunteer readers with preschool programs: <www.read2kids.org>.

The **America Reads** challenge is to support teachers to ensure that all students are proficient readers by the end of grade three. The Web site has information on activities in various counties across the state, a calendar of state and national literacy events, a chat room for teachers, literacy research, and good practices to consider in developing local programs: <www.literacynet.org>.

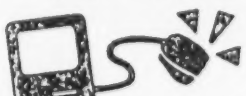
Playground Safety

The new "California Playground Safety Regulations" may be downloaded at no charge from the **California Code of Regulations** Web site. Request Title 22, Division 4, Chapter 22: <http://www.calregs.com>. You will also need to obtain two documents that have been extensively incorporated by reference into the regulations: "Guidelines for Public Playground Safety," from the **U.S. Consumer Product Safety Commission**, which may be downloaded from <http://www.cpsc.gov>; and "Performance Specifications for Playground Equipment for Public Use, ASTM Designation: F 1487-98," *which is protected by copyright and must be purchased* (the cost is approximately $45). For more information call the **American Society for Testing and Materials** at (610) 832-9585 or visit the Web site: <http://www.astm.org>.

To find a Certified Playground Safety inspector in your area, call the **California Parks and Recreation Society** at (916) 665-2777 or visit its Web site: <http://www.cprs.org>.

Collaborative Partnerships

The **Child Care Partnership Project** is supported by a contract from the Department of Health and Human Services to provide practical information on creating and maintaining public–private partnerships to increase and improve child care. It draws from the experiences of successful partnerships at the national, state, and local levels: <http://nccic.org/ccpartnerships/home.htm>.



Research

Policy Analysis for California Education is a policy research center whose primary aim is "to enrich education policy debates with sound analysis and hard evidence." Its Web site contains the center's newsletter, information on current research in early education and other areas, and ordering information on published reports: <http://www-gse.berkeley.edu/research/pace/>.

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